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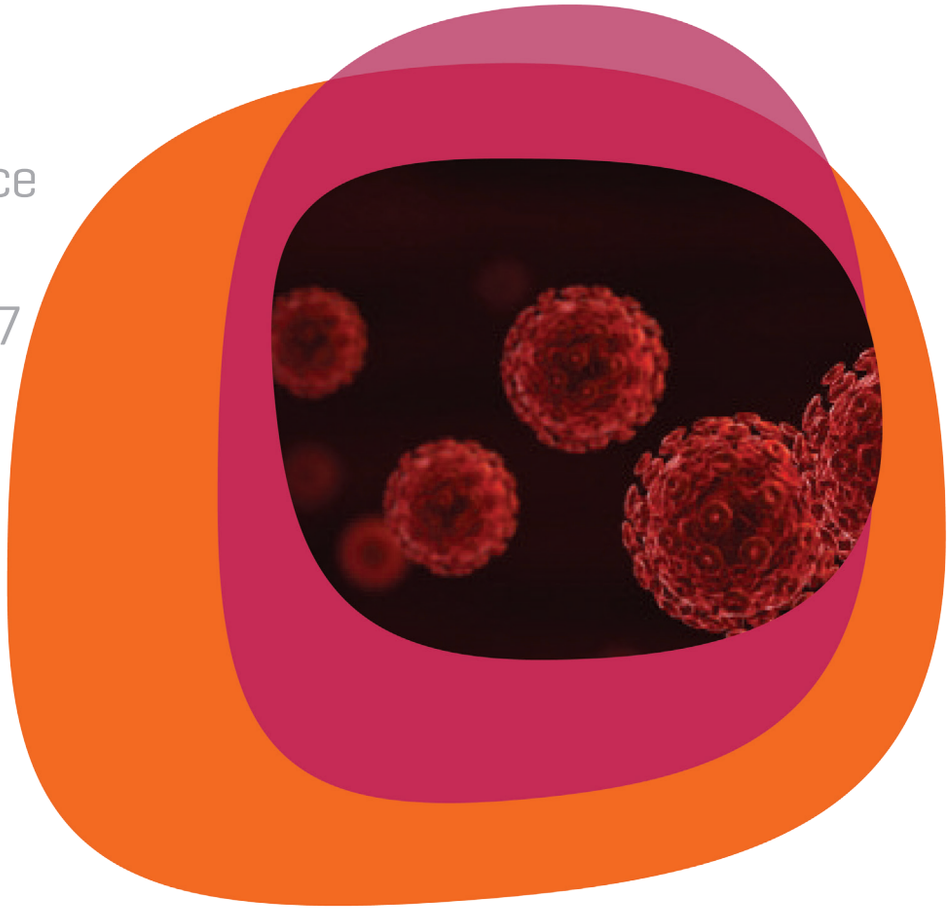

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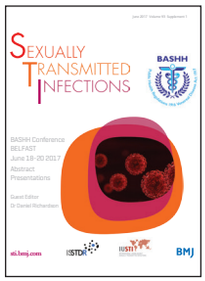

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Oral Presentations

O01 RECENT TRENDS IN HIV DIAGNOSES AND TESTS AMONG MEN WHO HAVE SEX WITH MEN ATTENDING SEXUAL HEALTH CLINICS IN ENGLAND

Dana Ogaz*, Martina Furegato, Alison E Brown, Hamish Mohammed, Peter Kirwan, Mandy Yung, Sophie Nash, Nicky Connor, Noel Gill, Valerie Delpech, Gwenda Hughes. *Public Health England, London, UK*

10.1136/sextrans-2017-053232.1

Introduction Men who have sex with men (MSM) remain at highest risk of HIV acquisition in England. We assessed recent national trends in HIV diagnoses and tests among MSM attending specialist sexual health clinics (SHCs) in England.
Methods Numbers of HIV diagnoses and tests in MSM were obtained from GUMCADv2, the national surveillance system for sexually transmitted infections. Trends were stratified by HIV testing history (new/repeat-testers in last 2 years) and service location (London/Outside-London). Student's t-tests were used to assess the differences in mean numbers of HIV diagnoses and tests between Q4/2014–Q3/2015 and Q4/2015–Q3/2016.
Results A decline in HIV diagnoses from 515 to 427 (17%) was observed between Q4/2014–Q3/2015 and Q4/2015–Q3/2016 (p=0.05). Greatest declines were in London SHCs (276–209; 24%; p=0.04) and among new-testers (390–308; 21%; p=0.03). In London SHCs, there was a 29% diagnosis decline among new-testers (195–138; p=0.03) with no evidence of a difference in repeat-testers (81–71; p=0.33); HIV tests in repeat-testers increased 15% (9,768–11,270; p=0.02) but remained stable among new-testers (7,166–6,638; p=0.28). In Outside-London SHCs, HIV diagnoses remained stable in new- (194–170; p=0.06) and repeat-testers (44–48; p=0.52) while HIV testing increased 14% in new- (7,679–8,734; p=0.05) and 16% in repeat-testers (7,423–8,602; p=0.02).
Discussion HIV diagnoses among MSM have decreased despite overall increased testing at SHCs. Stable levels of testing in new-testers as well as scale-up of repeat-testing may be contributing to diagnosis declines by earlier identification of undiagnosed infections. Further investigation of treatment and prevention initiatives among new- and repeat-testers in London SHCs is necessary.

O02 WHAT ARE THE MOTIVATIONS AND BARRIERS TO EFFECTIVE HIV PRE-EXPOSURE PROPHYLAXIS (PREP) USE FOR BLACK MEN WHO HAVE SEX WITH MEN (BMSM) AGED 18–45 IN LONDON? RESULTS FROM A QUALITATIVE STUDY

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10.1136/sextrans-2017-053232.2

Introduction PrEP has the potential to transform the HIV epidemic in the UK. BMSM experience a significantly higher HIV prevalence compared with other MSM meaning that PrEP rollout should be attentive to reducing health inequalities in this group. This research aims to describe the motivations and barriers to PrEP use for BMSM aged 18–45 in London.
Methods Twenty-five BMSM were recruited through social sexual apps for semi-structured interviews. All participants reported sexual behaviours consistent with PrEP candidacy. Interviews were transcribed verbatim and analysed using a thematic framework informed by inter-sectionality theory.
Results An 'ideal' PrEP candidate was frequently perceived to embody characteristics that participants themselves did not necessarily identify with (e.g. that they were insufficiently risky or sexually active to require PrEP). Many already felt marginalised by virtue of being both black and gay, or felt 'type-cast' as sexually dominant within the gay scene. Concern was expressed that taking PrEP may exacerbate such marginalisation by suggesting that they were also promiscuous. For others, however, taking PrEP meant avoiding another marginalised identity: that of someone with HIV. Participants tended to prefer conveniently located clinics outside of traditionally 'black' areas. Accessing services from staff of similar ethnic backgrounds was difficult for many, except for staff also perceived as gay.
Discussion Marginalisation remains a key barrier for this group, and should be considered when developing PrEP interventions. Existing services are acceptable for delivering PrEP interventions, but staff need to be mindful, sex affirmative and focus on developing rapport with BMSM of similar ethnic backgrounds as themselves.

O03 IMPACT OF PREP ON SEXUAL BEHAVIOUR? SIGNIFICANTLY LOWER RATE OF RECTAL CT IN NON-PREP USERS IN THE DEFERRED PHASE OF PROUD DISAPPEARED WHEN EVERYONE HAD ACCESS TO PREP

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10.1136/sextrans-2017-053232.3

Introduction PROUD is uniquely placed to compare rates of STIs between PrEP users and non-PrEP users, and to provide longitudinal data in PrEP users between Nov12–Nov16. We describe reported STIs in the year prior to enrolment, and rates during the deferred and post-deferred phases of PROUD when all participants had access to PrEP.
Methods Data were extracted from baseline self-completed questionnaires. Staff were asked to capture STI screens and diagnoses from quarterly study and interim routine clinic visits. We compared incidence rates of selected STIs for those with immediate (IMM) access to deferred (DEF) access during the deferred and post-deferred phase.
Results 517 participants completed the STI baseline questions, reporting a median (IQR) of 3 (2–4) screens in the 12m prior to enrolment; 172 (89 IMM, 83 DEF) reported a rectal infection. Rectal STI rates were similar by phase and arm with the exception of lower rates of rectal CT in the DEF arm during the deferred phase (p-value=0.024):

Abstract O03 Table 1 Rectal infections in PrEP

	Deferred Phase		Post-deferred Phase	
Rate (N/pyrs)	IMM	DEF	IMM	DEF
Rectal GC	35.3 (81/229)	33.7 (67/203)	31.4 (129/411)	32.7 (116/355)
Rectal CT	33.6 (77/229)	21.2 (43/203)	33.1 (136/411)	29.9 (106/355)

Discussion The ongoing high rates of rectal infections show that participants remaining in follow-up continued to need PrEP. The significantly reduced incidence of rectal CT in those allocated to deferred PrEP was not observed in the post-deferred phase when everyone had access to PrEP. This may be chance or may reflect an influence of PrEP on sexual practices.

O04 FINDINGS FROM THE MEN WHO HAVE SEX WITH MEN (MSM) INTERNET SURVEY IRELAND (MISI): ESTIMATED PROPORTION OF MISI RESPONDENTS ELIGIBLE FOR PRE-EXPOSURE PROPHYLAXIS (PREP)

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10.1136/sextrans-2017-053232.4

Introduction In Ireland, HIV infection predominantly occurs among men who have sex with men (MSM). Combination prevention approaches, including pre-exposure prophylaxis (PrEP), are recommended to reduce the risk of acquiring HIV. We used the 2015 MSM Internet Survey Ireland (MISI), a large-scale community survey among adult MSM in Ireland, to estimate the proportion of MISI respondents eligible for PrEP.
Methods We applied PrEP eligibility criteria from France to MISI variables. Where exact criteria could not be applied, the most similar form was used. French PrEP eligibility criteria include HIV negative MSM or transgender adults who had at least one of the following: condomless anal sex (CAI) with $\geq$2 different partners in the past six months; episodes of STIs in the past 12 months; used multiple post-exposure prophylaxis (PEP) treatment(s) or used drugs during sex.
Results MISI included 3,045 MSM aged 18–64 years; 2,870 (94%) were HIV negative or never HIV tested. In the past 12 months, 370(12%) reported CAI with $\geq$2 non-steady partners; 243(8%) reported an STI diagnosis and 181(6%) used drugs associated with chemsex. Four percent (n=119) were treated with PEP. Overall, 23% [95%CI(22–25)] of MISI respondents are eligible for PrEP.
Discussion An estimated one in four MISI respondents met French PrEP eligibility criteria. Applying this estimate to the MSM population in Ireland, taking study limitations, those engaged in services and assumed PrEP uptake into account, would enable calculation of the number of MSM eligible for PrEP. This estimate will be useful for informing PrEP policy in Ireland.

O05 EVALUATION OF THE IMPLEMENTATION OF AN EXPRESS 'TEST-AND-GO' HIV/STI TESTING SERVICE FOR MEN WHO HAVE SEX WITH MEN IN SEXUAL HEALTH CENTRE

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10.1136/sextrans-2017-053232.5

Introduction Men who have sex with men (MSM) who are asymptomatic and do not require treatment are eligible to use the new express HIV/STI testing service called 'Test-And-GO' (TAG) or the general clinic service for an asymptomatic screen. We aimed to evaluation the utilisation of the TAG service.
Methods MSM attending the clinic for a TAG service or a general clinic service between 5 August 2015 and 1 June 2016 were analysed. A general estimating equation regression model was constructed to examine the association between the use of TAG service and demographic characteristics, sexual behaviours, and HIV/STI diagnoses.
Results Of the 4,212 consultations, 750 (17.8%) were TAG consultations and 3,462 (82.2%) were routine consultations for asymptomatic MSM at the general clinic. MSM were more likely to use the TAG service if they were aged >30 years (OR=1.32 [95% CI 1.10–1.58]), were born in Australia (OR=1.40 [95% CI 1.16–1.70]), and had ≤4 male partners in the last 12 months (OR=1.30 [95% CI 1.12–1.52]) but there was no significant difference between condom use in the last 12 months. MSM who used the TAG service had less syphilis but there were no differences in detection of gonorrhoea, chlamydia and HIV diagnoses between the two services.
Discussion Demographic and some behavioural characteristics differed between the two services but other than syphilis there was no difference in STIs. The TAG service required less clinician time and hence created additional clinical capacity at the general clinic to see patients at higher risk.

O06 HEPATITIS C TRANSMISSION IN HIV NEGATIVE MEN WHO HAVE SEX WITH MEN (MSM) WHO DO NOT INJECT DRUGS

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10.1136/sextrans-2017-053232.6

Introduction Since 2000 there has been an increase in reported acute hepatitis C in HIV infected men who have sex with men which is associated with injecting drug use (IDU), condomless anal sex, pre-exposure prophylaxis (PrEP) use and sexual practices including fisting. There have been very few reports of acute Hepatitis C in HIV negative MSM who do not inject drugs. Locally we have been screening all MSM and IDUs per year for Hepatitis C since 2005.

Methods We looked at cases of hepatitis C diagnosed in our sexual health/HIV service per calendar year from 2012 – 2016 and looked at HIV status, injecting drug use and sexual behaviour.
Results We saw 37,012 attendances for sexually transmitted infection testing by MSM in the study period: There were 9 diagnoses of hepatitis C in HIV negative MSM in the study period. (2012:3, 2013:3, 2014:1, 2015:2, 2016:0). 5/9 HIV negative MSM diagnosed with hepatitis C gave a history of IDU. 4/9 HIV negative MSM diagnosed with (incident) Hepatitis C had no documented history of IDU, all had a recent history of condom-less anal sex at chem-sex parties; 2/4 had engaged in fisting and none were using PrEP at the time of diagnosis.
Discussion There appears to be a very small amount of hepatitis C transmission in HIV negative MSM who do not inject drugs associated with condom-less anal sex at chem-sex parties and fisting. Screening for hepatitis C could be rationalised to these groups of MSM.

007 NATIONAL RESPONSE TO AN OUTBREAK OF HEPATITIS A ASSOCIATED WITH MEN WHO HAVE SEX WITH MEN IN ENGLAND, 2016/2017

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10.1136/sextrans-2017-053232.7

Introduction Hepatitis A virus (HAV) is a vaccine-preventable infection, mainly travel-associated in the UK. Since July 2016 Public Health England has detected an increase in hepatitis A laboratory notifications in men who have sex with men (MSM). We described the outbreak characteristics to inform implementation of nation-wide control measures.
Methods A confirmed case was defined as a HAV infection with one of three outbreak strains and symptom onset after 31//6/16. Demographics, travel history and sexual behaviours were collected using a questionnaire.
Results By February 2017, 73 confirmed cases were detected across England. Of these 58 identified as MSM (median age 36 years) and 28 reported travel within the incubation period, primarily to Spain. 25% reported >1 casual partner in the previous 8 weeks. In addition to supporting the local public health response, PHE collaborated with national STI, HIV and liver associations to refine immunisation recommendations for at-risk MSM and alert front-line clinicians, and worked with the NHS and sexual health charities to raise awareness and promote personal hygiene and immunisation among MSM via social media, posters and leaflets.
Discussion The outbreak is likely associated with other MSM outbreaks with the same strains in other UK and European countries. The investigation suggests initial multiple importations from abroad followed by secondary sexual transmission within the MSM population in England. This outbreak highlights the need for MSM and healthcare professionals to consider the potential of HAV as a sexually transmitted infection, and the need to consider immunisation of MSMs where recommended.

008 HPV 16 AND 18 SEROPOSITIVITY AND DNA DETECTION AMONG MEN WHO HAVE SEX WITH MEN: EVIDENCE FOR THE POTENTIAL BENEFIT OF VACCINATION

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10.1136/sextrans-2017-053232.8

Introduction To estimate the prevalence of antibodies to HPV16 and HPV18, and genital HPV DNA among MSM attending a London sexual health clinic, to inform the potential benefit of vaccination in a high risk population.
Methods A cross-sectional study of 18-40 year-old MSM including a computer-assisted self-interview for behavioural data, and collection of extra-genital and intra-anal swabs, and blood. Anogenital samples were tested for 21 genotypes of HPV DNA using an in-house assay. Blood samples were tested for anti-HPV16 and HPV18 IgG by ELISA.
Results 496 MSM were included: among HIV negative MSM, HPV16 seroprevalence was 27% (95%CI 23–31) and HPV18 was 16% (13–20); HPV16 and 18 DNA prevalence 12.6% (9.8–15.9) and 6.0% (4.0–8.5) respectively. In HIV-positive MSM, seroprevalence was 58% (95% CI 37–77) and 35% (95%CI 17–56), and DNA prevalence 29.6% (13.8–50.2) and 11.1% (2.4–29.2) respectively.

After adjusting for age and lifetime partners, seropositivity for anti-HPV–16 and/or HPV–18 was associated with: HIV-positive diagnosis (HPV16-aOR: 3.16 [95%CI 1.37–7.28]), receptive anal sex in the last three months (HPV16-aOR: 3.39 [2.01–5.71]; HPV18-aOR: 2.14 [1.18–3.90]), use of drugs anally (HPV18-aOR: 2.07 [1.05–4.10]) and anogenital same-type DNA detection (HPV16 aOR: 3.58 [2.05–6.23]; HPV18 aOR:2.71 [1.17–6.27]).
Discussion Anogenital HPV DNA detection was less frequent than, but strongly associated with same-type HPV seropositivity. Most MSM attending a sexual health clinic had no serological or DNA evidence of exposure to HPV infection. This supports the case for the potential benefit of targeted HPV vaccination of MSM attending sexual health clinics, as currently being piloted in England.

009 THE IMPACT OF AN HPV VACCINATION PROGRAMME IN YOUNG MEN WHO HAVE SEX WITH MEN (MSM) ON CLINICAL PRESENTATIONS WITH GENITAL WARTS

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10.1136/sextrans-2017-053232.9

Introduction We introduced a quadrivalent HPV (HPV4) vaccination programme in young MSM <27yrs attending our clinical services (Clinic 1 & 2) since 2012. We assess the impact on attendance with genital warts (GW) subsequent to vaccination in this population and an adjoining service (Clinic 3) not then offering vaccination.

Methods We identified all MSM <27yrs receiving at least one dose HPV4 at Clinics 1 & 2, and all MSM <27yrs attending Clinic 3, between 2012 and 2017. Demographic and clinical data was extracted from electronic patient records. HPV DNA testing was not performed.

Abstract O09 Table 1 Clinical Outcomes in HPV4 vaccinated and unvaccinated MSM under 27yrs

Characteristic	Clinic 1& 2 HPV programme No./Total (%)	Clinic 3 No HPV programme No./Total (%)	Probability value p =
History of prior/current GW	75/757 (9.9%)	27/180 (9.6%)	p = 0.06
Ever Re-attended	524/757 (69%)	81/180 (45%)	p = 0.0001
Subsequent episode of GW: Re-attenders	11/524 (2%)	22/81 (27%)	p = 0.0001
Subsequent episode of GW: All	11/757 (1.5%)	22/180 (12%)	p = 0.0001
New cases of GW	3/757 (0.4%)	4/180 (2%)	p = 0.0285

Results Current or prior history of GW was comparable in the 2 clinic populations. Re-attendance rates were lower in the clinic without active recall. Recurrent episodes of GW was higher 22/180 (12%) in the unvaccinated population than the vaccinated group 11/757 (1.5%). Incidence of new cases of GW, defined as a first clinical episode > 3 months since 1st vaccine, was significantly lower in the vaccinated population.
Discussion We observed a significant reduction in subsequent episodes and potential new episodes of GW in an unselected population of MSM receiving HPV4 vaccine. Significant clinical benefit and saving can be expected from an HPV4 programme in MSM.

O10 AETIOLOGY OF AND TRENDS IN ANOGENITAL HERPES DIAGNOSES IN ENGLAND FROM 2006–2015

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10.1136/sextrans-2017-053232.10

Introduction Anogenital herpes (AH), associated with significant physical and psychological morbidity, is the second most commonly diagnosed viral sexually transmitted infection (STI) in England and is caused by infection with Herpes Simplex Virus (HSV) Type-1 or Type-2. We investigated the epidemiological and serotype characteristics of AH diagnoses in England and changes over time.
Methods We performed a descriptive analysis of socio-demographic and clinical characteristics of AH using data from the national surveillance system for STIs (GUMCADv2), and calculated the proportion of new episodes by serotype using data from the national laboratory surveillance system in England from 2006–2015.
Results There were 31,312 first and 25,356 recurrent AH episodes in 2015, and diagnosis rates of first episode AH increased 55% from 38 to 59 per 100,000 population since 2006. In 2015, diagnosis rates were highest among women (73.5), people aged 20-24 (243.1), those of Black Caribbean ethnicity (176.3), and London residents (93.8). Although MSM only accounted for 4.6% (n=1430) of diagnoses in 2015, there was an 18% increase in diagnoses since 2011; overall 28% of MSM diagnosed with AH were HIV-positive. The distribution of HSV-1/HSV-2 has remained stable since 2006: in 2015, 48% of women and 36% of men with AH were diagnosed with HSV-1 infection.
Discussion Increased diagnoses of AH may be due to changes in sexual practices or improved test sensitivity. Differences by socio-demographic characteristics can be used to inform prevention strategies, while those by serotype are essential for guiding vaccine development.

O11 USING A PROFESSIONAL PATIENT MYSTERY SHOP TO EVALUATE MANAGEMENT OF RECENTLY DIAGNOSED HSV-2, COMPARED WITH DATA FROM A NATIONAL QUESTIONNAIRE

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10.1136/sextrans-2017-053232.11

Introduction In 2014, the British Association of Sexual Health and HIV updated guidelines detailing the expected management of Anogenital Herpes type 2 (HSV-2). This study aims to evaluate counselling given to patients with HSV-2 and determine how clinicians are dealing with sensitive topics that arise during these consultations.
Methods 210 UK Genito-Urinary Medicine (GUM) clinics were sent an anonymous questionnaire, the results of which were analysed and compared with current guidelines. A pilot mystery shopping study, involving a patient with a reported recent HSV-2 diagnosis, was performed in 3 UK GUM Clinics. Details of each consultation were graded as A (acceptable), U (unacceptable) or C (a cause for concern) by a panel of 6 experts.
Results Analysis of the returned questionnaires showed inconsistencies in answers between clinicians and guidelines. The advice given during the visits was graded 69.7% A, 16.8% C and 13.5% U. Staff performed well with providing emotional support and guiding patients to extra materials (84.5% A) but did significantly less well on topics such as disclosure (65.9% A, p=0.0025), transmission (71.8% A, p=0.032) and pregnancy (53.9% A, p=0.000013) (Pearson's Chi-squared test).
Discussion The study has exposed some short falls in clinical practice, which should be addressed by future guidelines and education events at BASHH, should they be supported by a larger-scale study. Returning anonymised data to participating clinics may allow them to deal with discrepancies in their practice.

O12 LGV TESTING: ARE WE IDENTIFYING ALL CASES IN A TIMELY MANNER?

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Introduction BASHH recommends *Lymphogranuloma venereum* (LGV) testing of *Chlamydia trachomatis* (CT)-positive specimens from men who have sex with men (MSM) presenting with proctitis, and all rectal CT from HIV-positive MSM. Until recently in England, LGV testing was only available as a referred test at the Sexually Transmitted Bacteria Reference Unit (STBRU). In July 2016 we implemented a validated in-house version of the STBRU LGV PCR on all CT-positive specimens from MSM, regardless of symptoms or HIV status. We assessed the time from specimen collection to result (turn-around time, TRT) and defined clinical features of LGV cases.
Methods From July 2016 to March 2017 we reviewed all positive LGV tests, recording patients' demographics, HIV status, chemsex behaviour, presence of symptoms and LGV result TRT.
Results We conducted 587 LGV tests on CT-positive specimens from MSM, of which 50 (8.5%) were positive. Median age of LGV cases was 38 (range 23 to 65), 28 (56%) were Caucasian, 38 (76%) were HIV positive and chemsex behaviour was reported by 20 (40%); 12 patients (24%) had a past history of LGV. Nine (18%) cases were asymptomatic and three of these were HIV-negative MSM. The mean TRT was 12 days (range 8 to 20); compared with 35 days (range 15 to 118) in the six months prior to in-house testing.
Discussion LGV continues to occur mainly in HIV-positive MSM as symptomatic proctitis. Testing all CT-positive MSM increased detection of LGV compared with following BASHH guidelines, and in-house testing reduced TRT significantly.

O13 'I WAS STRUGGLING TO FEEL INTIMATE, THE DRUGS JUST HELPED'. CHEMSEX AND HIV-RISK AMONG MEN WHO HAVE SEX WITH MEN (MSM) IN THE UK: SYNDEMICS OF STIGMA, MINORITY-STRESS, MALADAPTIVE COPING AND RISK ENVIRONMENTS

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Introduction There has been a steep rise in the use of drugs during sex by some men who have sex with men (MSM), with associated increases in sexual risk for HIV and other STIs. This 'Chemsex' has been described, but there is a lack of theoretical perspectives applied to this particular phenomenon.

We aimed to assess participants' reasoning and conceptualisation of Chemsex and situate this within theoretical frameworks.
Methods This study presents data from telephone interviews with 15 MSM attending sexual health clinics following a risk of HIV and accessing post-exposure prophylaxis (PEP). Interviews were conducted as part of a larger interventional study, which used an adapted version of Motivational Interviewing to explore risk behaviour and support change. We used Framework analysis on interview transcripts in order to understand participants' perspectives on the use of chemsex.
Results Participants conceptualised their chemsex and HIV risks in their psycho-social context, highlighting the influence of the psycho-socio-cultural challenges of homophobic marginalisation and the 'gay scene' on their behaviour. Narratives of loneliness and difficulties in forming satisfying social and sexual relationships were repeatedly identified.
Discussion Multiple influences of stigma, minority stress and maladaptive coping (including drug-use) are seen to contribute to syndemic 'risk-environments' in which chemsex and risk behaviours are played out. Interventions to address the harms of chemsex must recognise the complex psychosocial context of risk, and shift the responsibility for change from vulnerable individuals to a shared responsibility distributed across social, political and institutional contexts.

O14 CHEMSEX, CONSENT AND THE RISE IN SEXUAL ASSAULT

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10.1136/sextrans-2017-053232.14

Introduction Within the chemsex population reports of sexual assault, non-consensual sex and coercion are rising. We looked at consent among our chemsex clinic users.
Methods Retrospective data review of patients from April 2015 to March 2017. Data was collected on sexual assault, coercion, exploitation, risk taking, sexually transmitted infections and drug use.
Results 72 men were seen with a median age of 32. 41 (56.9%) were HIV positive, and 11 (15.3%) had Hepatitis C. 53 (73.6%) patients used Mephedrone, 40 (55.6%) GHB and 22 (30.6%) Crystal Meth. 13 (18.1%) patients reported self-harm. In total 23 (31.9%) patients reported non-consensual sex. A minority 5/30 (16.7%) were identified from April 2015 to Jan 2016 when using the terminology 'forced into sex'. After realising that addressing consent is more complex in this cohort, we prioritised consent discussions around unwanted sexual attention and from Jan 2016 to March 2017 18/42 (42.9%) reported non-consensual sex (Table 1).

Abstract O14 Table 1 Chemsex

Assault/coercion	N/42 (%)
Non-consensual sex	18 (42.9%)
Reported as sexual assault	6 (14.3%)
Coercive sex	4 (9.5%)
Sex while unconscious	3 (7.1%)
Assaulted > once	2 (4.8%)
Allegations of organised assault	2 (4.8%)
Injected/filmed while unconscious	1 (2.4%)

Discussion Our data shows rates of non-consensual sex among chemsex users of up to 42.9%. There is a lack of patient understanding around what sexual assault and consent are and exploring this in a sensitive manner is paramount. Sexual assault discussions must be reviewed in both standard sexual health and chemsex clinics.

O15 A SERVICE EVALUATION COMPARING HOME-BASED TESTING TO CLINIC-BASED TESTING FOR CHLAMYDIA AND GONORRHOEA IN BIRMINGHAM AND SOLIHULL

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10.1136/sextrans-2017-053232.15

Introduction Public Health England recommends that local authorities should work towards making STI testing more accessible. Since August 2015, sexual health services in Birmingham and Solihull area (Umbrella) have provided online home-based testing.
Methods We conducted a retrospective analysis of the clinic and online database to identify patients who undertook home-based and clinic-based testing in the Birmingham and Solihull clinics between January and June 2016.
Results

Abstract O15 Table 1 Home based v clinic based testing

	Home-based testing (n=9258)	Clinic-based testing (n=19193)	P value
Age			
16–24	6033 (65%)	9654 (50%)	<0.001
>25	3225 (35%)	9539 (50%)	
Gender			
Female	5986 (65%)	10861 (57%)	<0.001
Male	3258 (35%)	8306 (43%)	
Transgender	14 (0%)	26 (0%)	
Ethnicity			
White	6648 (72%)	7996(42%)	<0.001
Black/British Black	892 (10%)	4026 (21%)	
Asian/British Asian	558 (6%)	2167(11%)	
Other:	920 (10%)	2160 (11%)	
Not specified:	240 (3%)	2844 (15%)	
Asymptomatic	7408/9258 (80%)	9729/19193 (51%)	<0.001
Return rate	4476 (48%)	–	
Prevalence rates	382/4476 (9%)	2141/19193 (11%)	<0.001
Treatment rate	174/382 (46%)	1663/2141 (78%)	<0.001

Discussion Home-based testing appears to be popular among asymptomatic, younger (16–24 years), white and female patients, with poor overall return rates. There may be a need for promotion of this method of testing among ethnic minorities. The current method of recall needs to be reviewed to improve treatment rates in the home-based testing group.

O16 ACCEPTABILITY, UPTAKE AND IMPACT OF ONLINE HOME-SAMPLING FOR STIS IN HAMPSHIRE, UK: A SERVICE EVALUATION

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10.1136/sextrans-2017-053232.16

Introduction Home-sampling offers cost-effective and equitable approaches, allowing hard-to-reach populations to remotely access screening for sexually transmitted infections (STIs). We aimed to evaluate a pilot home-sampling service - its utilisation, acceptability and impact on clinic attendance and service delivery, notably its capacity to direct 10% of asymptomatic clinic attenders to the online service.
Methods We ran descriptive statistics on six-month data (Sep 2015–Mar 2016) on STI kit requests and completion in Hampshire, and conducted trend analysis to examine the impact on attendances. Overall acceptability was assessed via online feedback survey and in-depth interviews with service users.
Results In total, 4,305 kits were requested and 1974 (48%) were returned, with 15% providing insufficient blood samples. After analysis, 73 samples were positive (1 HIV, 1 syphilis, 5 Hepatitis-B, 53 Chlamydia, and 13 Gonorrhoea). There was no significant reduction in asymptomatic attendances since the introduction of the service (p=0.12). While 95% would use the online service again and 93% would recommend it to family and friends, 39% reported difficulties taking blood samples.
Discussion Online home-sampling is an acceptable method of screening for STIs. The overall positivity rates are comparable to those reported in the clinic. However, the introduction of the online home-sampling might not reduce clinic attendances, due to the novelty aspects of the service. Further development of online screening needs to increase kit return rate and educate service users on more effective ways of providing sufficient samples for blood analysis.

O17 TRANSFORMING SEXUAL HEALTH SYSTEMS THROUGH ONLINE SERVICES

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Introduction Online sexual health services can transform sexual health systems through increased access and self-management. They are one element of the whole sexual health economy. Best practice facilitates appropriate movement of users between online and clinic services according to their sexual health need.
Methods Using routinely collected, anonymised service activity data, SHHAPT codes, and interviews with users/providers we studied online options for system transformation in sexual health services in two London Boroughs with high rates of sexual ill health. We focused on: Total sexually transmitted infection testing capacity; Access for new populations; Testing and treatment choices; Online contraceptive pills provision
Results Online services increase STI testing capacity, total testing in the area by 9.6% from 73,714 (01/04/14–31/3/15) to 80,757 (01/04/15–31/03/16). 90.8% of online users were asymptomatic with a positivity rate of 6.8%. Users move between online and clinic – 55% of online users had used a clinic within the last year and 6.8% of online users were referred to clinics. The online service engaged new populations – 19% of online users had never used a clinic before. 11,353 treatments for chlamydia were provided across the whole system (2015/16). A pilot of online treatment and partner notification shows 95% uptake demonstrating the potential impact of an online only chlamydia management pathway. Users engage with online medical histories, self reported blood pressure and SMS based clinical conversations for contraceptive prescribing.

Discussion Online services can transform sexual health systems by increasing capacity, increasing access and by offering new treatment choices.

O18 INTERNET TESTING FOR CHLAMYDIA REPORTED THROUGH NATIONAL SURVEILLANCE IN ENGLAND

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10.1136/sextrans-2017-053232.18

Introduction To support and monitor growth of online testing, the National Chlamydia Screening Programme published guidance on commissioning online testing services. Coding was amended in national surveillance systems to differentiate tests requested online from testing in other venues.
Methods National surveillance data from January 2015–September 2016 were linked to the IMD 2015 and ONS urban rural classification indices to analyse the trends in online testing and test positivity by gender for 15–24 year olds. Patterns of repeat testing were explored.
Results 163,062 tests and 13,422 diagnoses were reported from online services covering 89% of local authorities in England. Test positivity was higher in men (10% vs. 7.6% women; RR 0.80, $p<0.0005$), residents of urban areas (8.4% vs. 7.4% rural; RR 1.08, $p=0.002$) and those living in the most deprived areas of England (9.6% vs 7.0% least deprived; RR 0.79, $p<0.0005$). Test positivity online was higher than in general practice (8.2% vs GP 6.1% $p<0.0005$) and lower than in specialised sexual health services (8.2% vs 9.9% GUM and 9.5% SRH $p<0.0005$). In 2015, 18% of online testers had a subsequent online test within 6 months. Test positivity was higher at first than subsequent test (8.5% vs 7.3%).
Discussion Patterns in online test positivity were comparable with those found in other services suggesting that they are used by the population at risk not just the 'worried well'. Around 1-in-5 of those testing online had subsequent online tests. These findings support the provision of online testing services as well as face-to-face venues.

O19 WHO USES ONLINE SERVICES WHERE? A COMPARISON OF ONLINE STI TESTING SERVICE USE ACROSS ENGLAND

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10.1136/sextrans-2017-053232.19

Introduction Online sexual health testing services may enable access to testing by different sectors of the population. An innovative online sexual health service designed to improve access to and availability of sexual health services in partnership with terrestrial services is commissioned in seven areas across England. This study compares use across commissioned areas.
Methods We used routinely collected testing data to analyse use of the service in different areas. We included cumulative data on use of the service since roll-out.
Results In areas outside London, fewer users had been to a clinic before (66.5%–73.1% vs 81.1%). Positivity rate was also generally higher outside London (6.8 – 11.0% vs 6.8%). The majority of users were asymptomatic, which is appropriate for the service. Within the London boroughs, the majority of users (51.8%) were in the 25–34 age bracket while in all other areas there was a higher proportion of younger users. In all areas, females used the service more than males. Use by ethnicity was related to local area demographics.

Abstract O19 Table 1 Use of service as of end November 2016

	Area 1	Area 2	Area 3 (London)	Area 4	Area 5	Area 6
Orders to date	9760	462	15,924	713	1,048	1,726
Return rate	68.8%	58.9%	71.1%	76.9%	76.7%	78.9%
Positivity rate	7.6%	11.0%	6.8%	6.8%	9.0%	10.4%
% asymptomatic	90.1%	89.2%	90.8%	85.6%	86.6%	85.5%
Clinic visited before	66.5%	67.1%	81.1%	73.1%	66.7%	67.1%

Discussion The online service increased access to STI testing in all commissioned areas and shows important differences in online service use in different geographical regions. This may reflect differences in unmet need and access to terrestrial services. Further work is needed to understand these differences.

O20 ONLINE PRESCRIBING FOR SEXUALLY TRANSMITTED INFECTIONS – WHAT'S ON OFFER!

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10.1136/sextrans-2017-053232.20

Introduction In 2016, The British Association of Sexual Health and HIV (BASHH) expressed concern over the use of medications purchased online to treat Sexually Transmitted Infections (STIs) 'without full examination and specialist input'. Few studies have investigated the extent of this practice; our service wanted to establish availability of treatment and determine if patients are managed according to BASHH guidelines.
Methods A prospective internet search was performed using the keywords 'STI treatment online'. UK based internet pharmacies offering treatment for Gonorrhoea, Chlamydia, Herpes and Trichomonas were included in the study.
Results 30 websites were identified; 5 were excluded. 25 (100%) required assessment by a Doctor/Pharmacist Prescriber. 5(20%) offered Gonorrhoea treatment; of these, only one offered Ceftriaxone 500mg/Azithromycin 1 gram and no websites made customers aware that Gonorrhoea cultures were required prior to treatment.

23(92%) websites offered Chlamydia treatment as Azithromycin 1 gram stat and/or Doxycycline 100mg twice daily for seven days however, none of the websites asked whether treatment was required for patients at risk of rectal Chlamydia or Lymphogranuloma Venereum. Patients seeking Chlamydia treatment were advised to abstain from sex on 16(64%) websites and partner notification was advised on 18(72%) websites.

22 (88%) websites offered treatment for Herpes. 6(27%) required no photographic/laboratory diagnosis of Herpes before purchase. 15(68%) did not discuss partner disclosure of a Herpes diagnosis.
Discussion Online pharmacies have established a niche market for patients who are reluctant to access clinic based healthcare. Our results show variable adherence to BASHH guidelines which may compromise health outcomes for patients seeking internet based therapy.

O21 HIV TESTING IN ABORTION SERVICES: MISSED OPPORTUNITIES FOR EARLIER DIAGNOSIS

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10.1136/sextrans-2017-053232.21

Introduction The 2016 National Institute of Clinical Excellence (NICE) HIV testing guidelines reiterated the need to include HIV testing in abortion services. This survey aimed to determine whether HIV testing was commissioned in abortion services and how much testing was performed.
Methods 143 CCGs were invited to provide service specifications and monitoring data for the number of women seen for care, tested for HIV and diagnosed as HIV positive.
Results Of 103 CCGs that responded, 45 (42%) stipulated that HIV testing should be offered to all women, 10 (9%) requested that providers work towards this, 27 (26%) requested sign-posting and 21 (20%) had no mention of HIV. All 10 CCGs in extremely high HIV prevalence areas (where diagnosed HIV is >5/1000) commissioned HIV testing. 54% (14/26) of CCGs in high prevalence areas (diagnosed HIV is 2–5/1000) and 45% (30/367) of CCGs in low prevalence areas (diagnosed HIV is <2/1000) did so. 40 of 103 CCGs reported testing data. Of 35,023 women reported as seen for care, 35% (12,179) were tested for HIV and 0.14% (17) tested positive. Uptake ranged from 0% to 97% and positivity ranged from 0% to 0.53%.
Discussion Overall positivity rates exceed those required to make HIV testing cost effective. Less than half the CCGs reported commissioning HIV testing in abortion services, including 54% in high prevalence areas. These gaps in service provision mean opportunities to diagnose women earlier; thereby improving their prognosis and reducing undiagnosed infection were missed. Further advocacy for testing HIV testing in abortion services is required.

O22 ACCEPTABILITY OF HIV SELF-TESTING AMONG MEN WHO HAVE SEX WITH MEN ATTENDING A SEX ON PREMISES VENUE IN BRIGHTON: A CROSS SECTIONAL SURVEY

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10.1136/sextrans-2017-053232.22

Introduction Interventions to target and test men who have sex with men (MSM) for HIV are crucial to reduce incidence. Accessing traditional healthcare services can act as a barrier to HIV testing. Testing in outreach settings, such as sex on premises venues (SOPV), may be more successful. This study aimed to determine the acceptability of HIV self-testing in MSM sauna clients.
Methods An anonymous cross sectional, electronic/paper survey was conducted in a male SOPV in Brighton. Results were collated using Survey Monkey.
Results A total of 281 clients responded. 23% were aged 25–34 years, 16% 35–44 years and 37% 45–64 years. 32% reported never testing for HIV; 56% had not tested in the last 12 months; 44% felt they were not at risk of HIV. 93% would consider collecting a HIV self-test at the sauna with 40% wanting to test there and then, and 53% preferring to test at home.
Discussion A significant number of MSM attending this SOPV felt they were not at risk of HIV, and had never tested for HIV or not tested for over 1 year. Despite this, most individuals found testing at the SOPV acceptable, and would consider HIV self-testing if it were available. Innovative methods to enable HIV self-testing in venues frequented by high risk MSM are urgently needed.

O23 IMPACT OF SERVICE RELOCATION ON NEISSERIA GONORRHOEAE CULTURE SENSITIVITIES

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10.1136/sextrans-2017-053232.23

Introduction Our hospital-based GUM clinic *Neisseria gonorrhoeae* (NG) cultures were directly plated, stored in a CO2-enriched incubator and portered twice daily to onsite microbiology. Service relocation in November 2015 to a citycentre hub and 4 community sites forced change due to distance from microbiology. Community samples are taken on charcoal swabs, taxied to the hub at close of clinic for plating. Hub samples are directly plated. All plates are incubated 48–72hrs and transported daily in CO2-enriched environment (not temperature controlled).
Aims/objectives Evaluate sensitivity for NG culture against positive NAAT before and after service relocation.
Methods Cases of NAAT positive NG with a culture taken January–June 2015 were compared with cases January–June 2016. Hub and community results were merged in 2016 due to small numbers from community.
Results Overall sensitivity per infected patient (any positive NAAT and culture from any site) 2016 176/253 (70%) versus 2015 218/279 (78%), OR 0.64 (95% CI 0.43–0.94), p=0.02. Total sites with positive NAAT and associated culture processed: 2015 n=375, 2016 n=333.

Culture sensitivity by site of positive NAAT 2016 versus 2015: Urogenital 78% versus 85% (OR 0.63(0.37–1.08); p=0.09), Rectal 39% versus 55% (OR 0.52(0.29–0.94); p=0.03), Pharynx 33% versus 51% (OR 0.49(0.25–0.96); p=0.04).
Discussion Despite extensive review of evidence to identify systems that would maintain NG culture sensitivity, the overall sensitivity of NG culture has dropped significantly since the community move. There has been a non-significant decline in urogenital culture sensitivity but significant reductions in rectal and pharyngeal sensitivities. A new method for NG transportation is now under consideration.

O24 WHICH SEXUALLY TRANSMITTED INFECTIONS DO GAY AND BISEXUAL MEN FIND MOST SCARY AND WHY? A QUALITATIVE FOCUS GROUP STUDY IN FOUR CITIES IN ENGLAND

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10.1136/sextrans-2017-053232.24

Introduction Men who have sex with men (MSM) are a priority for STI prevention interventions including the promotion of regular testing and condom use. Effective intervention design requires understanding of MSM's knowledge and fear of STIs, which may affect attitudes and behaviour related to risk, testing and treatment.
Methods We recruited a diverse sample of MSM in four English cities, through social networking sites and community organisations. 61 men attended eight focus group discussions. Topics included knowledge and attitudes towards 11 STIs. Discussions were audio recorded, transcribed and analysed thematically.
Results Participants demonstrated variable knowledge and awareness of STIs. No focus groups were unanimous in their ranking of fear of STIs, although HIV and HCV were considered the most 'scary' in all groups. Fear of syphilis and herpes was also considerable. Gonorrhoea was considered a 'rite of passage' and was not widely feared. Other infections showed no clear patterning within or between groups. Participants suggested a complex range of explanations for fear of particular STIs. Participants weighed up the scary and less scary attributes depending on the extent of their knowledge and experience, their prevalence among MSM, associated stigma, transmission mechanisms, contagiousness, symptoms, severity, and the availability, effectiveness and ease of use of vaccines, treatment and/or cure.
Discussion Participants expressed a range of nuanced fears and concerns related to individual STIs and STI testing and treatment. Understanding these fears, and how they might be mitigated, will help improve the impact of interventions promoting STI testing and treatment.

O25 'SIDE CHICKS', AND 'SIDE DICKS': UNDERSTANDING TYPOLOGIES AND DRIVERS OF CONCURRENT PARTNERSHIPS TO PREVENT STI TRANSMISSION AMONG PEOPLE OF BLACK CARIBBEAN ETHNICITY IN ENGLAND

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10.1136/sextrans-2017-053232.25

Introduction In Britain, STI diagnoses rates and concurrent partnerships are higher among black Caribbeans than other ethnic groups. Concurrency (having sexual partnerships overlapping in time), especially when condoms are not used, can enhance STI transmission probabilities. We sought to understand concurrency typologies and drivers among black Caribbeans in England.
Methods 52 black Caribbeans (n=20 men) aged 15–70 years were recruited from community settings and STI clinics. 4 audio-recorded focus group discussions (n=28 participants) and in-depth interviews (n=24) were conducted from June 2014–December 2015. Transcribed data were thematically analysed to identify concurrency typologies and reasons.
Results Open, situational, and experimental concurrent partnerships were described. Open concurrent partnerships involved having a main partner and additionally men and women having sex with '*side chicks*'/'*thots*' and '*side dicks*', respectively. Situational partnerships involved sex with an ex-partner, especially their child's parent, while also having another partner. These partnerships were usually long-term, and condomless sex was common due to emotional attachment, to '*entice*' the ex-partner back, or because the relationship was founded on sexual pleasure. Experimental partnerships, common among single participants who were unsure about the type of partner to settle down with, were usually short-term and mostly involved condom use. Concurrency was perceived to be normalised in black Caribbean popular music, on social media, and fuelled by ease of '*ordering sex via app*'.
Discussion Understanding of different types of concurrent partnerships experienced by black Caribbeans during clinic consultations can increase the likelihood of effective partner notification. Interventions addressing normative drivers of concurrency are also needed.

O26 'IT JUST GIVES YOU THE HEEBIE JEEBIES': LATE MIDDLE-AGED ADULTS' ENGAGEMENT WITH KNOWLEDGE OF SEXUALLY TRANSMITTED INFECTIONS

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10.1136/sextrans-2017-053232.26

Introduction Rates of sexually transmitted infections (STIs) among adults over 45 are rising in the UK and other Western countries. While STI rates are higher among men who have sex with men and young people, there is increased fluidity of sexual partnerships across the life course, exemplified by midlife divorce and re-partnering, with sexual activity continuing beyond the age of 80. In order to develop a risk-reducing intervention for this age group, this qualitative study sought to understand the socio-cultural factors influencing late middle-aged adults' knowledge of STIs.
Methods Recently sexually active heterosexual adults aged 45–65 (n=31) were recruited from a large city sexual health service and sport and leisure centres. In-depth individual interviews explored how STI-related knowledge was acquired across the life course. Interview data were transcribed and analysed thematically.
Results Most participants (n=19) lived in areas of high deprivation and most were divorced, separated or bereaved from partners (n=24). Two key themes revealed that STI-related knowledge was acquired over the life course through personal social circumstances and wider cultural influences: 1) early stigmatisation of STIs influenced current understandings and 2) women in particular learned about STIs through parenting their adolescent children. Further themes showed that 3)

knowledge of STIs was stated tentatively and 4) current STI knowledge did not necessarily facilitate health-seeking behaviour.

Discussion Engagement with STI-related knowledge among middle-aged adults is influenced by socio-cultural factors including the enduring stigmatisation of STIs. Interventions tackling stigma should aim to recognise and legitimate changing sexual partnerships across the life course.

O27 BEYOND SEXUAL HEALTH: IDENTIFYING HEALTHCARE NEEDS OF TRANS AND GENDER VARIANT PEOPLE IN A SPECIALIST CLINIC SERVICE

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10.1136/sextrans-2017-053232.27

Introduction Sexual health services targeted towards specific populations have been an effective way of responding to complex needs. As demand for gender identity services increases, a trend in hormone self-medicating has become more apparent with patients obtaining treatment from internet pharmacies, friends or illicit sources. This study highlights the healthcare needs of patients attending a clinic service for transgender patients.

Methods Clinical audit of a sexual health service for transgender people in 2015 and 2016.

Results 81 attendances were recorded (56 unique patients). Median age was 32 (IQR 24–41). Reported gender identity: Trans male (Assigned Female At Birth [AFAB]) 29 (51.8%), Trans female (Assigned Male at Birth [AMAB]) 15 (26.8%), Non-Binary (AFAB) 9 (16.1%), Non-Binary (AMAB) 3 (5.4%). AMAB patients were older than AFAB – Median age 39 vs. 29 years ($p=0.03$). Most attendances were for STI screening or genital health issues – 47 (58%). 6 (7.4%) attended for psychosexual assessment. 31 (38.3%) attended for endocrine advice and monitoring of hormone therapy. 13 (38.3%) patients were self-medicating (10 Trans male/Non-Binary AFAB, 3 Trans female/Non-Binary AMAB). 7 of the trans male and 1 of the trans female patients were using intramuscular hormones. Only 2 of the patients self-medicating had informed another healthcare professional.

Discussion The number of patients self-medicating without medical supervision raises concerns about adverse effects and unsafe injecting practice. Identifying such patients and meeting their needs raises novel issues for sexual health services. The study highlights the need for additional education for clinicians working with transgender patients.

O28 EXPERIENCE OF FEMALE GENITAL MUTILATION (FGM) IN A SEXUAL HEALTH CLINIC

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Introduction After recommendations from the Intercollegiate Guidelines in 2013, our sexual health clinic introduced a diagnostic code and mandatory proforma to identify, record and report FGM.

Methods Retrospective case note review of all patients coded FGM.

Results All patients presenting were over 18. There were 210 FGM patients; 30/210 Type 1 (clitoridectomy); 40/210 Type 2 (excision); 35/210 Type 3 (infibulation); 79/210 Type 4; 26/210 unclassified. 71 had consensual FGM as adults; of whom 69 were Type 4 (typically genital piercing), 2 were Type 1.

In FGM performed under 18 years old (139); average age of cutting was 6 years. Countries involved; Somalia 67% (93/139), Sierra Leone 7% (9/139), Eritrea, Nigeria and Ethiopia 4% (6/139) respectively. 14% (19/139) reported complications.12% (17/139) had prior reversal. 4% (6/139) expressed interest in reversal. 98% (136/139) knew FGM is illegal in the UK.

Abstract O28 Table 1 Associations if FGM performed under 18 years old or over 18 years old.

Association	FGM types 1–4 <18yrs	FGM type 1–4 >18yrs	P value
Pelvic pain/PID	**17%** (23/139)	**6%** (4/71)	**0.0289**
HIV/Hepatitis B/C	**11%** (15/139)	**3%** (2/71)	**0.0596**

There was no significant difference in the rates of bacterial STI's between both groups.

Discussion Our proforma assists in identifying and accurately recording information regarding FGM. No women required referral to police or social services. Some were signposted for surgical intervention. An increased incidence of pelvic pain was noted in those whose FGM was performed as children, with no reflected increase in bacterial STI's. An increased prevalence of blood borne viruses was also noted. Most women reported negative attitudes to FGM. Sexual health clinics are well placed to assist in awareness, risk assessment and education surrounding FGM.

O29 PATIENT EXPERIENCES OF SEX EDUCATION IN SCHOOLS – BRIDGING THE GAP

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10.1136/sextrans-2017-053232.29

Introduction Rates of STIs are increasing in the UK among young people: here is little data on the quality, coverage and outcome of sex education in schools.

Methods A Self-completed service-evaluation survey of patient experiences of sex education and subsequent sexual health was offered to all patients aged under 25 attending our GP level 2 sexual health service in November 2016.

Results 110 completed surveys were returned; Median age was 20. 64% F, 35% M, 1% Trans*. 23% identified as LGBT. 27/110(24.5%) reported previous diagnosis with an STI. 92/110 (83%) were educated in the UK; 10/110(9%) reported no sex education at all. 55% of respondents felt that the majority of their sex education came via school. The most covered topics in school sex education were: Puberty (81%), Contraception (80%) and STI's (80%). LGBT relationships (8%) and Anal sex (9%) were rarely included. Safe internet use was discussed with 18% of respondents, and consent with 39%. 63% felt they had enough information to protect themselves. 38%

Females and 33% MSM reported having sex without consent, conversely only 8% Heterosexual men reported non-consensual sex. 51% respondents would use a sexual health clinic to gain more information about sex, 55% would use a website for information.

Discussion Sexual health services may be ideally placed to work alongside schools in providing sex education. It must not be assumed when seeing patients that they are fully aware of how to protect themselves from sexual harm, and steps must be taken to address any gaps in knowledge attendees may have.

030 TREATMENT FAILURE IN MYCOPLASMA GENITALIUM AMONG GUM CLINIC ATTENDEES

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10.1136/sextrans-2017-053232.30

Introduction Macrolide resistance in *Mycoplasma genitalium* (MG) is of growing concern in countries where azithromycin is used to treat non-gonococcal urethritis(NGU) but UK data is lacking. Patients with NGU or pelvic inflammatory disease (PID) are routinely tested for MG at our clinic and offered test of cure (TOC) 4 weeks post-treatment. We aim to determine rates of MG-positivity 4 weeks after treatment and their associations.

Methods Notes of MG-positive cases between December 2015 and November 2016 were reviewed and data collected on management.

Results 114 cases of MG were identified. 91(80%) were symptomatic and 12(11%) were MG contacts. Should be 52/339 (15%) men with NGU and 15/160(9.4%) women with PID were MG-positive.

80/114(78%) were given an azithromycin regimen first line. 59/114(53%) returned for TOC and 24/59(40%) were positive (23 following azithromycin; 1 following moxifloxacin). 19 returned for a second TOC and 14 were negative (1 following azithromycin and 13 following moxifloxacin second line). 5/19(26%) were positive (3 following azithromycin and 2 following moxifloxacin second line). One male patient with confirmed resistance to macrolide and quinolone therapy achieved microbiological cure with pristinamycin.

Having a positive TOC was significantly associated with risk of reinfection ($p=0.01$) and being symptomatic at TOC ($p<0.001$), but not significantly associated with gender, sexual orientation, HIV status, concurrent STI ($p=0.053$) and azithromycin use.

Discussion MG-positivity rates at 4 week TOC are high raising concerns of treatment failure although re-infection may also contribute. As commercial assays are imminently available, diagnoses of MG will increase and where possible should be accompanied by antimicrobial resistance testing.

031 EXPLAINING ETHNIC VARIATIONS IN STI DIAGNOSIS: RESULTS FROM BRITAIN'S THIRD NATIONAL SURVEY OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL-3)

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10.1136/sextrans-2017-053232.31

Introduction In Britain, ethnic inequalities in STIs diagnoses persist. We hypothesised that these inequalities are associated with variations in sexual behaviour, which are influenced by differences in socioeconomic deprivation (SED) and mediated by substance use.

Methods Data from 14,563 participants of Britain's third National Survey of Sexual Attitudes and Lifestyles, a probability sample survey (N=15,162), were analysed by gender and ethnicity: white British (WB, reference category), black Caribbean (BC), black African (BA), Indian, Pakistani, white other (WO), and mixed ethnicity (ME). Using multivariable regression we examined ethnic variations in reported STI diagnoses adjusted for age, partner numbers (last 5y), recreational drug use (last 1y), and SED, and calculated adjusted odds ratios (AOR).

Results SED was higher in BC, BA, and Pakistani participants than other ethnicities (50% vs. 16%-38%, $p<0.0001$). compared with men from other ethnicities, BC and BA men reported higher partner numbers ($p<0.0001$), and concurrent partnerships (27% and 39% respectively vs. 4%–15%, $p=0.001$). compared with women from other ethnicities, ME women reported higher partner numbers ($p<0.0001$) and concurrency (14% vs. 2%–8%, $p=0.0005$). Recreational drug use was highest among WO and ME participants (26% vs. 4%-15% among other ethnicities; $p<0.0001$). Reported STI diagnosis was highest among BC men (8.7) and ME women (6.7%), and remained AOR high after adjustment for BC men (2.68, 95%CI: 1.13–6.34) and ME women (2.03, 95%CI: 1.11–3.68).

Discussion Ethnic variations in sexual behaviours, mediators, and SED partially explain higher STI diagnoses among BC men and ME women highlighting need for holistic interventions addressing these broader determinants.

032 ETHNICITY AND SEXUAL BEHAVIOURS – THE ASSOCIATION BETWEEN ETHNICITY AND SEXUAL RISK BEHAVIOURS REPORTED BY HETEROSEXUAL MEN AND WOMEN IN A GUM SETTING

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10.1136/sextrans-2017-053232.32

Introduction In the UK people of black ethnicity experience a disproportionate burden of HIV and STI. We aimed to assess the association of ethnicity with sexual risk behaviours (SRB) and sexual health among heterosexual men and women.
Methods AURAH is a cross-sectional questionnaire study of people without HIV, recruited in 20 GUM clinics in England 2013–14. We assessed the association of ethnicity with (i) condomless sex with non-regular partner(s) (CLS-NR); (ii) ≥2 new partners in the last year (2NPLY); and (iii) STI diagnosis in the past year (STI) using modified poisson regression adjusted for age, study region, education and relationship status.
Results 1075 heterosexual men (n=451) and women (n=624) completed questionnaires. Ethnicity was as follows: 513 (48.4%) black/mixed African (BA), 159 (15.0%) black/mixed Caribbean (BC), 288 (27.1%) white ethnicity (WE), 101 (9.5%) other ethnicity (OE).

Abstract O32 Table 1 AURAH

Adjusted PR (95%CI)	CLS–NR	2NPLY	STI within last year
Women: White	1	1	1
BA	**0.65(0.49–0.85)**	**0.36(0.27–0.48)**	0.92(0.61–1.38)
BC	0.78(0.55–1.10)	**0.39(0.25–0.61)**	1.47(0.95–2.28)
OE	0.66(0.39–1.13)	**0.60(0.37–0.99)**	1.23(0.68–2.23)
Men: White	1	1	1
BA	1.05(0.83–1.32)	**0.77(0.62–0.96)**	1.14(0.75–1.73)
BC	1.02(0.73–1.44)	0.85(0.62–1.16)	**1.76(1.10–2.82)**
OE	0.69(0.43–1.09)	1.29(1.03–1.61)	0.59(0.24–1.43)

Compared with WE women BA women were less likely to report CLS-NR, BA and BC women were less likely to report 2NPLY, and BC women were more likely to report STI. In men CLS-NR did not vary significantly by ethnicity. BA men were less likely to report 2NPLY and BC men were more likely to report STI compared with WE men.
Discussion The prevalence of SRBs was lower in black ethnicity women, but history of STI was more prevalent among BC women. Similarly, higher STI history in BC men was not consistent with ethnic variation in SRB. Additional factors, e.g. sexual networks, may be important determinants of sexual health.

O33 SIGNIFICANTLY HIGHER RATES OF CHLAMYDIA FOUND IN ARMY PERSONNEL COMPARED WITH NON-MILITARY CLINIC ATTENDEES

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10.1136/sextrans-2017-053232.33

Introduction Our Sexual Health service covers a county-wide population, including large numbers of Army personnel. Despite military personnel being recognised as high risk for sexually-transmitted infections (STIs), accurate data on STI and HIV epidemiology within the military is lacking (1).The latter is compounded by difficulties differentiating military from civilian patients attending Sexual Health clinics. We introduced a local code ('ARMY') from April 2016. This has enabled us to monitor numbers of Army attendees and compare STI rates and risk factors with non-military patients.
Methods Local 'ARMY' code added by clinicians at time of consultation, based on information including: patient self-reported occupation, garrison address, military uniform.

Electronic patient records for all male new or rebook attendees between 15/4/16 and 31/10/16 with an 'ARMY' code were reviewed (n = 234). These were compared with a non-military group of patients (n=234) attending during same time period and were matched for age group, gender, sexuality and presence/absence of symptoms.
Results Army personnel were found to have significantly higher levels of chlamydia positivity (19.2%) compared with non-military attendees (11.1%) (p= 0.020, Fisher's exact 2-tail). This higher rate of chlamydia was found despite comparable numbers of: sexual partners in prior three months, presentations as chlamydia contacts and high-risk alcohol users. Rates of gonorrhoea, warts, HSV, HIV and syphilis did not differ significantly. Army personnel were significantly more likely to be of non- white British ethnicity (11.1%) than non-military attendees (2.1%), reflecting local population (p =0.0001, Fisher's exact 2-tail).
Discussion Our findings support promotion of sexual health screening for military personnel and targeting of chlamydia testing. Military personnel often go home to other areas of UK and overseas during leave and could disseminate infections.

O34 BINGE DRINKING, SMOKING AND EXPERIENCE OF INTIMATE PARTNER VIOLENCE AMONG WOMEN AGED 16–44 YEARS ATTENDING SEXUAL HEALTH CLINICS

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10.1136/sextrans-2017-053232.34

Introduction BASHH guidance includes assessment of smoking history, intimate partner violence and alcohol risk in Sexual Health (SH) clinics. As part of a study assessing psychosocial predictors of sexual risk among women of reproductive age, we investigated the prevalence of these issues and their associations with sexual risk.
Methods A convenience sample of women aged 16–44 years attending a busy urban integrated Contraception and Sexual Health clinic was invited to complete a questionnaire about socio-demographic, sexual behaviour and psychosocial factors.
Results Of n=532 eligible women 44.5% were aged 16–24 years. 42.1% of participants reported binge-drinking (6+ units on one occasion) on a weekly basis. 36.7% reported currently smoking cigarettes or roll-ups. Using an adapted HITS domestic violence (DV) measure, 16.1% were classified as currently or previously experiencing DV. None of these factors was associated with reported risk of unintended pregnancy in the last 6 months. Multiple partnerships in the last year was not associated with DV experience (p=0.187) but remained positively associated, after adjustment for age, with current weekly binge-drinking (adjusted odds ratio = 2.13) and with current smoking (AOR =1.87).
Discussion Findings suggest that interventions for binge-drinking, cigarette smoking and DV may be warranted for a

substantial minority of women attending SH clinics. In particular observed associations between binge-drinking, cigarette smoking and multiple partnerships may point towards broader lifestyle choices that could be addressed concomitantly in SH clinics to help reduce sexual risk behaviour.

O35 SPATIAL AND TEMPORAL ASSOCIATIONS BETWEEN SEXUALLY TRANSMITTED AND RECENT CONGENITAL SYPHILIS CASES IN ENGLAND

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10.1136/sextrans-2017-053232.35

Introduction Four infants with congenital syphilis (CS) born to UK-born mothers who screened syphilis negative at first trimester antenatal screen were identified in England between March2016–January2017. Simulation modelling using historic data suggested the probability of observing these events was about 1%. We assessed whether these recent CS cases were associated with underlying epidemiology of infectious syphilis (IS).

Methods Data from 01/2011–09/2016 were obtained from GUMCADv2, the national STI surveillance system in England. We defined three syphilis epidemiological areas (SEAs): wider incident areas (WIAs; the affected and immediate surrounding counties); endemic areas (established epidemics in men who have sex with men-MSM); non-incident/non-endemic areas (NINEAs). IS rates/100,000 population were derived and associations between IS characteristics and SEAs were assessed using bivariate analyses. Mothers of CS cases were excluded from analyses.

Results From 2011–2016, IS rates/100,000 in WIAs rose in heterosexual women (1.5–2.5, 67% increase) and MSM (9.0–13.7, 52% increase) but fell in heterosexual men (4.3–2.7, 37% decrease). In NINEAs, rates rose in heterosexual women (1.6–1.9, 19% increase), MSM (5.0–11.9, 138% increase) and heterosexual men (2.7–3.2, 18% increase). In 2016, the proportion of UK-born heterosexual women with IS was greater in WIAs (82%) than in NINEAs (81%) and endemic areas (35%;$p<0.001$). The proportion of MSM identifying as bisexual was greater in WIAs (14%) compared with NINEAs (9%) and endemic areas (5%;$p<0.001$).

Discussion Increased syphilis transmission among MSM in WIAs may have created opportunities for IS acquisition in women. Health promotion to raise awareness of potential risks of acquiring syphilis during pregnancy is needed.

O36 MANAGEMENT OF ACUTE EPIDIDYMO-ORCHITIS – SUPPORTING TWO SERVICES

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10.1136/sextrans-2017-053232.36

Introduction The mismanagement of acute epididymo-orchitis (EO) can have significant sequelae. Guidelines exist for the management of EO and we audited practice across two departments (Urology and Genito-Urinary Medicine [GUM]) within a District General Hospital.

Methods Case notes of patients attending with acute EO between June 2015 – June 2016 were analysed retrospectively.

Results 152 men were seen; 85 by Urology, 67 by GUM. Mean age at presentation was 49 years (range 17–89). A full sexual history was documented in 15.3% of Urology patients, compared with 100% of those seen by GUM. Conversely, a full urological history was documented in 25.9% of Urology patients, compared with 2% of GUM patients. The differences in investigations requested are shown in Table 1.

Of the urine samples sent for culture by Urology, 36.4% were positive, and 50% had antibiotic resistance.

As well as failing to test for STIs, none of the patients seen by Urology were given advice regarding sexual abstinence and contact tracing. These recommendations were made by the GUM team in 93% and 88% cases, respectively.

In GUM 94% of patients were prescribed recommended first or second line antibiotic therapy, compared with 11% in Urology who had a wide variation of antibiotic use.

Abstract O36 Table 1 Urology v GUM

Investigation	Urology (%) of patients tested	GUM (%) of patients tested
Urine dipstick	29.4	57.6
Mid-stream urine	51.8	28.4
Chlamydia/gonorrhoea -NAAT	0.0	97.0
Test for urethritis	0.0	36.0
Inflammatory markers	72.0	0.0
Serology for Blood-borne viruses	0.0	90.6

Discussion All patients in this audit were treated by teams with expertise in the management of EO. Our data shows despite well published guidelines being available, investigation and management could be improved. A combined clinical pathway for patients with acute EO could facilitate inter-speciality working and improve patient outcomes.

O37 GENITAL DERMATOLOGY IS A HIGH PROPORTION OF THE CASE LOAD PRESENTING TO WALK-IN SEXUAL HEALTH SERVICES ACROSS THE UNITED KINGDOM

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10.1136/sextrans-2017-053232.37

Introduction Patients with genital dermatology (GD) conditions frequently present to sexual health services. Following service tendering, there are reports of contracts excluding provision of specialist GD services within sexual health. We aimed to review the case load of GD conditions presenting to walk-in sexual health clinics, to reach an understanding of the demand for these services within our specialty.

Methods Members of the BASHH GD Specialist Interest Group collected data on the first 30 to 50 new symptomatic

patients presenting to their sexual health walk-in service on 5th September.

Results 382 patients presented to 9 services across England and Scotland. Of these, 164 (43%) presented with a GD condition. GD STI diagnoses (e.g. warts, herpes simplex) were excluded. 75 patients (20%) presented with non-STI GD conditions.

Of these, 59% were male, 91% heterosexual. The modal age range and ethnicity were 18–25 year olds (36%) and white British (67%).

GD diagnoses included: candida/tinea 17%, normal variant 11%, eczema 8%, non-specific balanitis 8%, irritant dermatitis 7%, vulvodynia 5%, lichen sclerosus 5%, lichen planus 3%, psoriasis 3%. 17% of cases required senior review. 33% had follow up: 32% by a Genitourinary Medicine consultant; 12% in a Genitourinary Medicine specialist clinic. 4% required skin biopsy.

Discussion Our study demonstrates that non-STI GD conditions constitute a high proportion of clinical presentations to walk-in sexual health services. Many cases require in-house senior input. Commissioners must recognise the burden of GD on services and the expertise required to ensure optimal management of GD within sexual health.

O38 THE CONTRACEPTION CHOICES INTERACTIVE DECISION-AID: DEVELOPMENT, CONTENT AND DESIGN

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10.1136/sextrans-2017-053232.38

Introduction Women have many concerns about contraception which can put them off using reliable methods, and their worries may not surface in consultations with health professionals. An online intervention can offer convenient help with decisions. We describe the design and development of the Contraception Choices website which addresses myths and misconceptions about contraception, and provides tailored recommendations for contraceptive methods.

Methods We gathered several sources of evidence: 1) A qualitative synthesis of systematic reviews of factors influencing contraceptive choice; 2) Views on contraception expressed on YouTube (35 videos); 3) A meta-analysis of randomised controlled trials of interactive digital interventions for contraceptive decision-making; 4) A narrative synthesis of reviews of interventions for contraceptive decision-making; 5) Seven focus groups with 75 women aged 15 to 30 recruited in clinical settings, to explore beliefs and concerns about contraception and suggestions for website content.

YouTube videos and qualitative data were analysed thematically. Themes from the qualitative field work and findings from the evidence reviews were tabulated, and implications for the design of the Contraception Choices website were debated.

Results The most common myths and misconceptions about contraception were worries about hormones being unnatural, weight gain, altered bleeding patterns, cancer and future infertility. The Contraception Choices website addresses women's concerns through videos, information which highlights contraception benefits, and an interactive tool which gives tailored suggestions for contraceptive methods.

Discussion The role of digital decision-aids for contraception will be discussed. The website will be tested in a pilot randomised controlled trial starting in March 2017.

O39 IMPROVING THE EVIDENCE-BASE TO UNDERSTAND STI RISK REDUCTION CAPACITY: THE FEASIBILITY AND ACCEPTABILITY OF LINKING ONLINE BEHAVIOURAL SURVEY DATA TO GENITOURINARY MEDICINE CLINIC RECORDS

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10.1136/sextrans-2017-053232.39

Introduction Behavioural surveys provide insight into the context associated with STI risk, but interpretation is hampered by using self-reported STI history. We aimed to determine the feasibility and acceptability of linking patients' online survey data on STI risk factors with the national surveillance dataset on STI diagnoses (GUMCADv2).

Methods Between May-September 2016, attendees at 16 GUM clinics across England were invited to complete an online survey on knowledge, attitudes, and behaviours around STI risk, using a clinic tablet or personal device. Clinic staff recorded respondents' patient IDs, which we used to link surveys to GUMCADv2 (as well as age, gender, and clinic attendance date). We examined recruitment and linkage success and used Z-test for proportions to assess selection bias.

Results 6283 attendees agreed to participate, and 73.6% (4626) did so, with survey completion higher in those who completed the survey in clinic vs. those who did so at home (87.3% vs 16.8%). 95.9% (4437) of survey respondents were eligible, which was 59.2% of our recruitment target. 91.2% (4046/4437) of participants consented to data linkage, and of these 88.9% (3596) were linked to GUMCADv2. Consent did not differ by age or gender but was higher among MSM than heterosexual men (95.5% vs. 88.4%; $p<0.01$), and lower among black Caribbean than white participants (87.1% vs 93.8%; $p<0.01$).

Discussion Online behavioural surveys distributed in GUM clinics with linkage to GUMCADv2 are both highly acceptable to attendees and technically feasible. Staff should encourage survey completion on clinic tablets to maximise recruitment and linkage success.

O40 ON BECOMING 'NORMALISED': HOW ARE PATIENTS COPING WITH THE TRANSFORMATION OF HIV INTO A 'CHRONIC DISEASE LIKE ANY OTHER'?

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10.1136/sextrans-2017-053232.40

Introduction The widespread use of modern ARVs has increased self-management in HIV patients and reduced their contact with HIV services. We explored how patients adjusted to the changing model of care.

Methods We conducted in-depth interviews with 52 adults from two HIV clinics. Participants were purposively sampled to achieve variation in: time since diagnosis and demographic characteristics. Data were examined using thematic analysis.
Results Three-quarters of the sample were virally undetectable, financially stable and generally healthy, although some experienced psychological problems and/or other STIs including HCV. Having adjusted well to the medical regimen they tried to 'normalise' their life by a combination of: asserting control over their virus by staying informed about their immunological status and scientific developments; using 'othering' methods to assure themselves of the uniqueness of their situation; and keeping their seropositive status hidden from most others. Gay men felt keeping HIV secret was similar to keeping their gayness secret, and being virally undetectable gave some respondents medical legitimacy to not disclose even to sexual partners. By contrast, a quarter of the sample felt the need for frequent contact with the HIV clinic, either because of co-morbidities or other vulnerabilities. Half of this group reported relations with their clinicians suggesting emotional dependency.
Discussion The chronic disease model of HIV management transforms HIV from a collective and political phenomenon into an individualised concern. While patients with complex needs continue to have frequent clinic contact, others isolate and conceal their HIV-positive identity to avoid experiencing stigma in their day-to-day lives.

Undergraduate Oral Presentations

UG1 MANAGEMENT OF SYMPTOMATIC PATIENTS ATTENDING OPEN ACCESS SEXUAL HEALTH WALK-IN CLINICS IN THE UK

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Introduction Following the NHS Act 2012, Sexual Health services (SHs) have been radically reshaped. Anecdotally many places report problems in maintaining open access services, particularly since local authorities became responsible for commissioning SHs as of 1 April 2013.
Aims To assess whether SH walk-in clinics can accommodate symptomatic patients and if there is a difference in waiting time between male and female patients. To determine whether the expectations of lead clinicians working in SHs concur with the experience of front line services.
Methods A postal questionnaire was sent to 262 UK SH clinics to assess lead clinicians' predicted waiting times. Four researchers; 2 males and 2 females attended clinics as 'patients' reporting symptoms suggestive of an acute STI, clinic waiting time was recorded. 50% of clinics in each of the 17 BASHH branches were visited. SPSS v23 was used to analyse the data.
Results Of the 131 clinics visited, 97.7% could accommodate symptomatic 'patients' on the same day. The observed waiting time ranged from 5-285 minutes. The median wait was 54 minutes respectively. There was no significant difference in waiting time between male and female 'patients' ($p=0.110$). 68/262 questionnaires were returned; 31 were from clinics which were visited. 13% of clinics underestimated the walk-in waiting time, while 23% over-estimated the walk-in waiting time, when compared with actual walk-in waiting time established during clinic visits.
Discussion Despite strains on SHs, most clinics visited could accommodate patients on the same day. However, there is discrepancy between lead clinicians' expectations and services provided.

UG2 THE ASSOCIATION BETWEEN BIRTH ORDER AND SEXUAL HEALTH OUTCOMES:HOW IS BIRTH ORDER ASSOCIATED WITH LEARNING ABOUT SEX, EARLY SEXUAL EXPERIENCE, AND SEXUAL RISK BEHAVIOUR?

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Introduction While the effect of birth order on psychosocial outcomes has been widely discussed in the literature, little research examining birth order effects on sexual health has been undertaken. This analysis identifies the associations between birth order and learning about sex, first sexual experiences and sexual risk behaviours.
Methods This analysis uses data from Natsal-3, a stratified probability sample survey of 15,162 men and women aged 16–74 in the UK. Bivariate logistic regression was conducted to identify crude odds ratios for the association between birth order and sexual health outcomes. Multivariate logistic regression was performed adjusting for socio-demographic factors and sibling number.
Results Middle-born and last-born men were less likely to have found it easy to speak to their parents about sex around age 14 (OR 0.59, p=0.003; OR 0.69, p=0.009) and to have learned about sex from their mothers (OR 0.64, p=0.014; OR 0.76, p=0.045). Last-born women were less likely to report a parental main source of sex education (OR 0.64, p=0.003). Being a last-born male was associated with decreased odds of having had 5+ lifetime heterosexual partners (OR 0.75) and reporting ever had heterosexual anal sex (OR 0.77).
Discussion These results provide the basis for further research on the association between birth order and learning about sex, and highlight later-born males in particular as being less likely to report parental involvement in sex education. Qualitative research is recommended in order to gain a broader understanding of the ways in which birth order effects manifest in learning about sex.

UG3 CONNECT EMAIL – 8 YEARS' EXPERIENCE OF AN EMAIL CLINIC IN AN HIV OUTPATIENT SETTING

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Introduction With advances in HIV therapy, many people are living longer healthier lives. Simultaneously our cohorts are ageing with 42% of individuals locally aged over 50. Our service looked for innovative ways of reducing visits for stable patients while increasing capacity to manage complex patients.

In 2008 we introduced an email service whereby patients are seen once a year with interim results checked and emailed to them. We report on a review of the Connect email service.

Methods Individuals who had ever registered with the email service and their current status were identified from our prospective clinical database. Reasons for 'exiting' or 'pausing' the service were identified by a case notes review. A service evaluation was carried out via staff and patient surveys.

Results Since October 2008, 888 individuals have registered with our email service: 89.8% male (n=797); median age 48 (range 22–84). At the time of review (Oct 2016) 550 (550/2370 = 23% of total cohort) were under active email follow-up. In eight years, 171 (19.3%) have 'exited' the email service - reasons included: co-morbidities (46.2%); ARV switch/start (18.7%); patient choice (12.9%) and non-attendance/adherence (11.1%). A further 167(18.8%) has been 'paused', mainly due to co-morbidities (58.1%); ARV switch/start (20.4%) and research (16.2%). Non-attendance/adherence was more common in younger patients while co-morbidities predominated among older patients (aged >50). In the staff survey, barriers for enrolling patients on Connect included 'difficulty letting go' of regular appointments, email access and confidentiality concerns.

Discussion As the email service is an integral part of HIV care in our unit, understanding why patients leave Connect and barriers to enrolment will enable continued effectiveness of the service.

UG4 THE PREDICTIVE VALUE OF TRIAGE QUESTIONNAIRES IN A SEXUAL HEALTH CLINIC

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Introduction To assess the effectiveness of self-completed triage forms in eliciting symptomatic status and predicting subsequent diagnoses.

Methods Consecutive patients attending a GUM clinic 3/10/16–7/10/16. Data from self-completed patient triage forms were extracted and correlated with clinician findings documented in electronic patient records at the visit. Fisher's Exact was used to calculate association.

Results 339 patients were included of whom 56.6% were female. Median age was 29 years (14–84) and 86.4% identified as heterosexual (n=293). 54.6% of patients (n=185) indicated symptoms on the triage forms c.f. 58.7% (n=199) documented as symptomatic by clinicians. Clinicians and patients agreed on symptomatic status in 85.3% (289/339) of cases. 57.7% (n=71) of symptomatic women reported lower abdominal pain (LAP), inter-menstrual/post-coital bleeding (IMB/PCB) or dyspareunia on triage forms which were subsequently documented by clinicians on 66.2% (41/71) of occasions. These symptoms were not significantly associated with a diagnosis of PID, or other infections, when documented by clinicians or patients ($p<0.05$). Patient and clinician documented 'change in vaginal discharge', 'lumps on genitals' and 'genital blisters or sores' were significantly associated with candidiasis and bacterial vaginosis ($p<0.05$), genital warts ($p<0.05$), and genital herpes ($p<0.05$) respectively. Patient and clinician reported dysuria was significantly associated with NSU in men and UTI in women ($p<0.05$).

Discussion There was a high level of concordance between patients and clinicians regarding symptomatic status. Specific symptoms, when included in triage, are effective predictors of associated diagnoses with the exception of LAP, IMB/PCB and dyspareunia which appear to be non-specific.

UG5 DESIGNING, DELIVERING AND EVALUATING A TEACHING TOOLKIT FOR PRE-EXPOSURE PROPHYLAXIS IN MEN WHO HAVE SEX WITH MEN

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Introduction Research on the knowledge of PrEP in healthcare workers including third sector workers is limited, and their knowledge will be vital to future national rollout. The aim of this study was to design and evaluate a teaching toolkit on PrEP to educate healthcare professionals and third-sector workers.

Methods A 20 minute powerpoint teaching toolkit was designed and delivered to sexual health workers, third sector workers and medical students. A questionnaire was used to evaluate the toolkit, including perceived knowledge pre-toolkit, immediate post-toolkit, and >1-week post-toolkit.

Results 42 participants took part in teaching sessions. There was a 36% increase in mean perceived participant knowledge scores (maximum = 25) immediately after teaching (23.69), and a 26% increase >1-week after teaching (21.93) – when both are compared with a prior mean score of 17.45. This change in perceived knowledge increased significantly both immediately post and >1-week post when compared with pre-toolkit ($Z = -5.351$, $p = <0.001$; $Z = -3.189$, $p = 0.001$). Immediately after, 42/42 (100%) participants agreed they had some knowledge of the monitoring and tests for PrEP in comparison to 21/42 (50%) pre-teaching ($Z = -4.753$, $p = <0.001$). Overall 39/42 (93%) of participants strongly agreed it provided a good overview of PrEP, with 35/42 (84%) thinking it would help them to provide answers to those seeking to use PrEP.

Discussion Perceived knowledge of PrEP increased following toolkit use and importantly was sustained >1-week post-toolkit when compared with prior knowledge. Toolkits such as this can help educate future PrEP advocates.

UG6 A RETROSPECTIVE COHORT STUDY OF TREATMENT OUTCOMES AMONG HIV POSITIVE INDIVIDUALS WITH EARLY SYPHILIS AT A SINGLE HIV CLINIC

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Introduction Guidelines for the treatment of early syphilis recommend benzathine penicillin G (BPG) for all patients regardless of HIV status. Concerns of HIV-positive patients developing asymptomatic neurosyphilis have prompted some to prescribe a neuropenetrative regimen of procaine penicillin (PP) with probenecid. There is heterogeneity in prescribing and the debate surrounding this issue is amplified by the global probenecid shortage. One centre in the UK has

historically treated patients with PP regardless of syphilis stage. We compared serological response, adherence and tolerance among these patients compared with those receiving alternative regimens.

Methods A retrospective analysis of HIV positive individuals with early syphilis infection. Response to treatment was defined by ≥4-fold decline in VDRL titer within 13 months.

Results 197 patients were diagnosed with primary(24%), secondary(50%) or early- latent(26%) syphilis between 2012-2015. 102(52%) received PP, 26(13%) BPG, 38(19%) doxycycline for 28 days and 4(2%) amoxicillin plus probenecid. For 27(14%), treatment regimen was unknown. Of those who completed PP, 91% had serological response, BPG 65%, doxycycline 79%. Four patients on PP switched due to non-adherence. Of the PP patients median age 42, CD4 576 and 80% were on antiretroviral therapy. This did not differ greatly between those who achieved serological response and those who did not.

Abstract UG6 Table 1 Demographics and follow up of patients divided by treatment regimen

	PP (%)	BPG (%)	DOXY (%)	AMOX+P (%)
No. of patients started treatment	102 (52)	26 (13)	38 (19)	4 (2)
No. of patients completed treatment	94 (92)	26 (100)	34 (89)	4 (100)
Serological Response	86 (91)	17 (65)	27 (79)	3 (75)
Serological Failure	3 (3)	1 (4)	3 (8)	1 (25)
Lost to Follow up <13 months	5 (5)	8 (31)	4 (11)	0
No. of patients did not complete treatment	8 (8)	0	4 (11)	0
Serological Response	7 (88)		3 (75)	
Serological Failure	1 (12)		1 (25)	
Switched Treatment Regimen	4 (4)	0	1 (3)	0
BPG	1 (25)	0	1 (100)	0
Doxycycline	3 (75)	0	0	0
Serological Response	4 (100)	0	1 (100)	0
Age				
Median	42	44	38	54
Range	25–46	29–68	27–58	40–63
Syphilis Infection				
Primary	24 (24)	9 (35)	7 (18)	1 (25)
Secondary	47 (46)	12 (46)	25 (66)	1 (25)
Early Latent	31 (30)	5 (19)	6 (6)	2 (50)
CD4 at Diagnosis				
Median	576	654	534	728
Range	126–1223	170–2384	274–847	404–1146
On ART at Diagnosis				
Yes	82 (80)	21 (81)	30 (80)	4 (100)
No	20 (20)	5 (19)	8 (20)	0

PP=procaine penicillin plus oral probenecid; BPG= benzathine penicillin G; DOXY= doxycycline; AMOX+P= amoxicillin plus oral probenecid; HART=HIV antiretroviral therapy

Discussion We demonstrate good adherence and tolerance of PP. There was a superior serological response to treatment in this group but a large loss to follow up among those treated with BPG. Further statistical analysis may identify factors associated with serological failure. Prospective studies exploring co-infection are required.

Poster Presentations

Bacterially Sexually Transmitted Infections

P001 WHAT IS THE EVIDENCE THAT PREVIOUS AZITHROMYCIN TREATMENT FOR CHLAMYDIA OR GONORRHOEA IS ASSOCIATED WITH NEISSERIA GONORRHOEAE AZITHROMYCIN RESISTANCE?

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Introduction The prevalence of azithromycin resistance in *Neisseria gonorrhoeae* (NG) including high-level resistance (HL-AziR NG) is increasing in England. It has been suggested that exposure to azithromycin at sub-optimal doses may facilitate development of azithromycin resistance in NG. We investigated whether treatment history for non-rectal chlamydia (CT) or NG (as proxies for azithromycin exposure) in GUM services was associated with susceptibility of NG to azithromycin.

Methods Descriptive and negative binomial regression analyses of azithromycin Minimum Inhibitory Concentration (MIC) data from 4608 NG isolates collected by the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) 2013–2015 (matched to GUMCADv2 data on CT/NG diagnoses) were performed. Descriptive analyses of previous CT/NG among 56 HL-AziR NG isolates (MIC>256 mg/L) were also performed (2013–2016).

Results Modal azithromycin MIC was 0.25mg/L (1 dilution below the resistance breakpoint) in those with and without history of CT or GC. There were no differences in MIC distribution by previous CT/NG, nor by time since most recent infection (CT: p=0.97; NG: p>0.99). Among patients with HL-AziR NG, 4 (8%) were treated for CT and 4 (8%) for NG in the previous year, compared with 9% and 13% respectively for all GRASP patients.

Discussion There was no evidence of an association between previous CT/NG treatment in GUM services and subsequent presentation with an azithromycin-resistant strain. However, 46% of CT diagnoses occur in non-GUM settings therefore further research is needed to explore whether an association with azithromycin exposure in other settings and for other conditions exists.

P002 ASSESSING THE IMPACT OF INDIVIDUALISED TREATMENT: AN INDIVIDUAL-BASED MATHEMATICAL MODELLING STUDY OF ANTIMICROBIAL RESISTANT NEISSERIA GONORRHOEAE TRANSMISSION, DIAGNOSIS AND TREATMENT IN MEN WHO HAVE SEX WITH MEN

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Introduction Antimicrobial resistant (AMR) gonorrhoea is a global public health threat. In London, diagnoses in men who

have sex with men (MSM) have more than quadrupled from 2010 to 2015. Importantly, our last-line treatment (ceftriaxone) is used in first-line dual therapy. However, over half of tested isolates are still sensitive to older drugs, e.g. ciprofloxacin. Discriminatory point-of-care tests (POCT) to detect drug sensitivity are under development, enabling individualised treatment decisions.

Methods An individual-based transmission model of gonorrhoea infection in MSM was developed, incorporating ciprofloxacin-sensitive and resistant strains, using novel heuristic approach to capture partnership dynamics. We explored different strategies to improve treatment selection including a) discriminatory POCT, b) partner treatment based on index case susceptibility, and c) variably delayed positivity testing prior to treatment (pre-screening).

Results The flexible model structure enabled us to credibly simulate London gonorrhoea transmission dynamics - assuming 2–10% prevalence and 10–50 daily diagnoses per 100,000 MSM. Simulations show that a) using POCT to detect ciprofloxacin sensitive infections resulted in a 70% decrease in ceftriaxone doses, and b) using index case sensitivity profile to direct treatment of partners could reduce ceftriaxone use by 27%.

Discussion POCT are likely to dramatically reduce reliance on ceftriaxone. In the meantime, we could use existing data more informatively. If lab turnaround times are fast enough, index case sensitivity profiles could be used to select effective treatments for partners. This new framework addresses limitations of previous models and provides a flexible platform for exploring control options for AMR gonorrhoea.

P003 GENITAL C. TRACHOMATISINFECTIONS LAST LONGER IN MEN THAN WOMEN, BUT ARE LESS LIKELY TO BECOME ESTABLISHED

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Introduction Rigorous estimates for the duration of untreated chlamydia infection are important for understanding its epidemiology and designing control interventions, but are only available for women. We have estimated the duration of untreated infection in men.

Methods Data came from published studies in which untreated, chlamydia-infected men were re-tested at a later date. We used analysis methods that had previously been applied to data from women, which allow for a new infection to take one of multiple courses, each clearing at a different rate. We determined the optimal number of possible courses. Parameter estimates were obtained using a Bayesian statistical framework.

Results The best-fitting model had two different courses of infection: 'slow-' and 'fast-clearing', as had been the case for women. In men only 68% (57%–78%) (median sample; 95% credible interval) of incident infections were 'slow-clearing', compared with 77% (69%–84%) in women. The posterior median estimate for the mean infection duration in men was 2.84 (0.87-18.79) years, compared with 1.35 (1.13–1.63 years) in women.

Discussion Our estimated infection duration in men is longer than has previously been assumed. Male infections are less likely to become established (slow-clearing) than those in women but once established, tend to last longer. Long-term, asymptomatic infections in men – in whom chlamydia screening rates are lower – could be sustaining chlamydia prevalence in both sexes. This study provides an improved description of chlamydia's natural history to better inform public health decision-making. We advocate further data collection to reduce uncertainty in estimates.

P004 PROSPECTIVE COMPARISON OF CHARCOAL SWABS VERSUS NEAR-PATIENT DIRECT CULTURE PLATE INOCULATION FOR THE CULTURE OF GONORRHOEA IN HIGH-RISK PATIENTS. A REPEAT AUDIT

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Introduction Gonorrhoea culture is required to monitor antibiotic resistance and is recommended for all patients known or suspected to be infected. In July 2016 a retrospective comparison of near-patient direct plating and transported charcoal swabs found that the culture positive rate was 24% lower for charcoal swabs. Since this audit, the laboratory service implemented an urgent transport system for charcoal swabs, in order to improve the reliability of this method.

Methods Between July 2016 and January 2017 all patients who had a positive GC NAAT or were otherwise at high risk had two culture swab specimens taken from the infected site (cervical, male urethra, rectum, pharynx): 1. a charcoal swab sent to the laboratory for plating within two hours and 2. specimen directly plated onto VCAT GC selective agar.

Results Of 139 positive NAATs across all sites, 47 were followed by both direct plating and charcoal swab. Of these 47 pairs of cultures, there were only 2 discrepancies between culture types (one with direct plating positive, charcoal negative, the other vice-versa).

Abstract P004 Table 1 Culture +ve rate by method and site

Site	Cervix	Urethra	Pharynx	Rectum	Total
No. of positive NAATs	28	50	36	25	139
No. of patients in whom both methods of culture/ transport used	5	24	9	9	47
No. (%) +ve by direct plate	4 (80%)	21 (88%)	2 (22%)	7 (77%)	34 (72%)
No. (%) +ve charcoal swab	4 (80%)	21 (88%)	2 (22%)	7 (77%)	34 (72%)

Discussion With the implementation of the new urgent transport system, there is no difference in the culture positive rates of direct plating versus charcoal swabs for GC culture. Provided the same high standards of transport are maintained, a change in practice, moving to charcoal swabs transported to the lab for GC culture and stopping direct plating, is recommended.

P005 QUANTIFYING THE FITNESS BENEFITS AND COST OF CEFIXIME-RESISTANCE IN NEISSERIA GONORRHOEAE

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Introduction Gonorrhoea is among the most common bacterial sexually-transmitted infections in the UK, over 41,000 cases were recorded in 2015, with over half in men who have sex with men (MSM). As the bacterium has developed resistance to each first-line antibiotic in turn, we need improved quantification of fitness-benefits and costs of antibiotic resistance to inform control policy. Cefixime was recommended as a single-dose treatment for gonorrhoea from 2005–2010, during which time resistance increased, and then subsequently declined. We hypothesise that there is a net fitness-benefit to cefixime-resistance when cefixime is widely-prescribed and a net fitness-cost when cefixime-prescriptions decline.
Methods We developed a stochastic compartmental model representing the natural history and transmission of cefixime-sensitive and -resistant strains of gonorrhoea in UK MSM, which was fitted to data on diagnoses and prescriptions over 2008-2015 using particle Markov Chain Monte Carlo (pMCMC) methods.
Results The model replicated the observed data and indicated that the fitness-benefit of cefixime-resistance exceeds its cost when cefixime is prescribed for >31% (95% CI [26%, 36%]) of gonorrhoea diagnoses, and that the resistant strain is fitter than the cefixime-susceptible strain when cefixime is prescribed for >51% (95% CI [43%, 62%]) of diagnoses.
Discussion The use of state-of-the-art pMCMC methods provided significant evidence in favour of our hypothesis and insights into the dynamics of cefixime-resistance in gonorrhoea. Our findings have important implications for antibiotic-stewardship and public health policies, such as targeted prescriptions and combination therapy; as well as emerging resistance through similar mechanisms to the current first-line treatment, ceftriaxone.

P006 CLINICAL EVALUATION OF THE RESISTANCEPLUS™ MG KIT, FOR DETECTION OF MYCOPLASMA GENITALIUM AND SCREENING FOR MACROLIDE RESISTANCE

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10.1136/sextrans-2017-053232.52

Introduction European guidelines on *Mycoplasma genitalium* (MG) infections and on the mangement of non-gonococcal urethritis strongly recommend NAAT testing for MG and screening for macrolide resistance. The ResistancePlus™ MG kit has been developed for the simultaneous detection of MG and five mutations in the 23S rRNA gene associated with azithromycin resistance.
Methods The ResistancePlus™ MG kit (SpeeDx) was evaluated in a prospective-restrospective study on 182 urogenital samples from patients routinely tested for Chlamydia and gonorrhoea. The ResistancePlus™ MG (550) kit was performed using the 7500 Fast (Applied Biosystems), after sample extraction on the MagNA Pure 96 Instrument (Roche) using the DNA and Viral NA Small Volume Kit following the Universal Pathogen 200 protocol. Results were analysed using the FastFinder ResistancePlus™ MG (7500) analysis software. Results were compared with an in-house qPCR test for MG detection with positives subsequently sequenced to determine 23S rRNA mutation status.
Results The ResistancePlus™ MG kit showed high clinical performance compared with the reference methods with sensitivity and specificity for MG detection of 98% and 100%, and 23S rRNA mutation detection of 92.5% and 100%, respectively. The ResistancePlus™ assay has an analytical sensitivity of 10-15 copies for all targets, and no cross-reactivity was seen in a wide range of non-target organisms.
Discussion The ResistancePlus™ MG kit demonstrated excellent clinical performance for the simultaneous detection of MG and mutations associated with macrolide resistance. Detection of MG with resistance information is capable of guiding personalised treatment at the first health-care visit, reducing clinical-care costs and reducing the spread of antimicrobial resistance.

P007 EFFECTIVE CLINICAL DESIGNS OF MULTIPLEX POINT-OF-CARE-TESTS FOR GENITAL DISCHARGE SYNDROME MANAGEMENT IN WOMEN: WHICH PATHOGEN COMBINATIONS AND TESTING PROTOCOLS DELIVER THE BEST OUTCOMES?

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10.1136/sextrans-2017-053232.53

Introduction Syndromic management of sexually transmitted infections (STIs) is common practice in sexual health clinics (SHC). Implementation of multi-pathogen point-of-care-tests (POCTs) can improve patient management by providing same day diagnoses and treatment. We assessed the potential impact of five POCT protocols consisting of tests for different combinations of *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG), *Mycoplasma genitalium* (MG) and *Trichomonas vaginalis* (TV) infections, on a standard care pathway (SCP), for 81 symptomatic female patients.
Methods 5 virtual POCT protocols (assuming 100% sensitivity and specificity) were analysed against diagnoses and laboratory results. Reflex tests (i.e. tests used dependent on the result of another test) were incorporated into protocols to investigate utility of testing for certain pathogens separately. McNemar's test was used to compare proportions of correct diagnoses from each protocol against each other and establish which is most effective. P values were adjusted using Holm-Bonferroni correction.
Results Protocol P1 was statistically the most effective at providing the correct diagnosis ($p=0.000$). P5 was also statistically more effective than the SCP ($p=0.001$). No significant differences were found between other protocols. Although P4 and P5 diagnosed equal proportions of patients, P5 had better performance ($p=0.001$) compared with P4 ($p=0.0012$).

Abstract P007 Table 1 Point of care test results

Testing protocols	Correct diagnoses (%)	95% Confidence Interval (%)
SCP	75.31	64.92 to 83.41
P1: CT/NG/MG/TV	100.00	96.96 to 98.30
P2: CT/NG + MG reflex	92.59	86.89 to 98.30
P3: NG/MG	88.89	82.04 to 95.73
P4: CT/MG + NG reflex	95.06	90.34 to 99.78
P5: NG/MG + CT/TV reflex	95.06	90.34 to 99.78

Discussion P1 was more effective than the SCP and all other protocols, however, may not be technically feasible. P5 was not statistically different from P1 and may be a valid alternative. Due to high rates of MG and CT infection in this cohort, a protocol including tests for both pathogens would be desirable for this population.

P008 A YEAR OF PROCTITIS: AETIOLOGY AND MANAGEMENT IN AN URBAN GUM CLINIC

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10.1136/sextrans-2017-053232.54

Introduction Chlamydia trachomatis (CT), including Lymphogranuloma venereum (LGV), Neisseria gonorrhoeae (NG), syphilis and herpes simplex (HSV) all cause proctitis in MSM. Local guidance recommends testing and treating for these organisms. We examined the aetiology and management of cases of proctitis at our sexual health clinics.
Methods Clinical records were reviewed of all men coded for proctitis between January and December 2016. Clinical presentation, microbiology results, and treatments issued at initial clinic visit were recorded and data analysed.
Results 46 MSM were correctly coded as having proctitis. The median age was 38.5(19–75) years. 21/46(45.7%) were HIV-positive. Presenting symptoms included: rectal discomfort (69.6%), discharge(47.8%), bleeding(39.1%), altered bowel habit(23.9%), and tenesmus(17.4%). 7/46(15.2%) had anorectal ulceration.

All patients were tested for CT and NG. NG was detected in 11/46(23.9%) and CT in 10/46(21.7%), including 4 with LGV. 27/46(58.7%) were tested for HSV, which was positive in 8/27(29.6%). 1 Mycoplasma genitalium and 4 Syphilis were diagnosed. Co-infections with >1 organism were identified in 8(17.4%). In 22/46(47.8%) no cause was identified. 41/46 (89.1%) MSM received antibiotics for CT. In 30/46(65.2%) MSM this included anti-microbial cover for NG and 17/46 (37.0%) had an extended course of doxycycline for LGV. Aciclovir was given to 12/46 MSM (26.1%).
Discussion NG was the commonest pathogen identified, however only 65% of MSM were treated. HSV testing rates were low despite one third of those tested being HSV positive. This indicates a need to better educate clinicians of the multi-pathogen, syndromic, approach to proctitis management to ensure that relevant pathogens are not missed.

P009 RISK OF CHLAMYDIA/GONORRHOEA NAAT CONTAMINATION FROM CLINIC SURFACES – NEED FOR PATIENT AND STAFF AWARENESS IN SELF-SWABBING AND POOLING AREAS

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10.1136/sextrans-2017-053232.55

Introduction A self versus clinician Chlamydia/gonorrhoea (CT/NG) NAAT swab trial, with pooling of self-taken samples, recruited January 2015–September 2016. There was concern that nucleic acid contamination of clinic surfaces could be a source of false-positive samples during the pooling process.
Aim(s)/objectives To ascertain levels of environmental nucleic acid contamination within clinic environments. To determine number of false positive pooled samples throughout study.
Methods Environmental samples of clinic rooms, sluices and toilets were performed and tested using Aptima Combo 2 throughout duration of study. In November 2015, the clinic relocated from old premises to a newly renovated site.

Results were disseminated to staff throughout to raise awareness and to reduce risk of contamination during sampling/pooling. Posters in self-swab areas highlighted risk of contamination, importance of handwashing and no surface contact for swabs.
Results Of 41 environmental sampling episodes over 12 months, 17 (41%) were CT/GC positive/indeterminate. These were distributed throughout the whole 12 months. Positive results were obtained from surfaces in all clinical examination rooms at the old site and toilets and sluices (where urines were pipetted) at both sites. 3/4 clinic rooms regularly used for examination at the new site remained contamination free. There were 7 false positive pooled samples (6 female, 1 male); all were in the first 6-months of the study.
Discussion Nucleic acid contamination was repeatedly found throughout the clinic despite regular cleaning/decontamination. Raising staff and patient awareness did not reduce contamination but it did reduce false positive pooled samples, with none occurring after the first 6-months.

P010 ROUTINE USE OF DOXYCYCLINE FOR FIRST-LINE CHLAMYDIA TREATMENT: HOW HARD CAN IT BE?

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10.1136/sextrans-2017-053232.56

Introduction BASHH guidelines advise either azithromycin 1g stat or doxycycline 100mg bd 7 days as first line treatment for uncomplicated Chlamydia infection. In practice, azithromycin 1g is favoured in many clinics due to perceptions of better adherence, tolerability and efficacy. Evidence has mounted of suboptimal efficacy of azithromycin, yet guidelines and practice remain unchanged. We routinely use doxycycline as first line treatment for Chlamydia infection. We sought to audit this practice, investigate rates of intolerance and adherence and explore treatment failure in those who had follow-up testing.

Methods For all patients treated for Chlamydia during Jan–Mar 2016 we extracted clinical and treatment information from notes and follow-up phone calls. We collated results of patients who had a repeat Chlamydia test performed within 6 months after treatment.
Results Data were available for 215 Chlamydia-positive patients: 82 heterosexual men, 66 MSM and 67 women; 96 were treated as symptomatic patients or Chlamydia contacts and 116 were recalled for treatment. Overall 92% were treated with doxycycline. From follow-up data only 3.0% reported failing to complete treatment, citing vomiting and forgetting to take tablets as reasons. 40% of patients had a repeat Chlamydia test within 6 months, with a 14% positivity rate. All such patients had either on-going sexual risk or evidence of failed PN.
Discussion Discontinuation rates and evidence of persistent infection are low with routine use of doxycycline for Chlamydia. Clinics reluctant to make a switch to first-line doxycycline for Chlamydia and NGU might find these data useful.

P011 TREPONEMA PALLIDUM PCR (TP-PCR) IS A USEFUL DIAGNOSTIC TEST IN ADDITION TO SYPHILIS SEROLOGICAL (STS) AND DARK GROUND MICROSCOPY IN EARLY DIAGNOSIS OF PRIMARY SYPHILIS

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10.1136/sextrans-2017-053232.57

Introduction There has been a significant increase in infectious syphilis in men who have sex with men (MSM) since 2000. We have been using a local Tp-PCR in conjunction with dark ground microscopy and serology in patients with genital ulcer disease to increase the sensitivity of primary syphilis diagnosis. The aim of this project was to evaluate the increased diagnostic yield that Tp-PCR offers our service.
Methods We reviewed the microbiology (syphilis serology and Tp-PCR) of patients coded as primary syphilis between December 2015 and December 2016. We also collected demographic data on these cases.
Results 74 patients were accurately coded as having primary syphilis all of whom were MSM (24/74(32%)) HIV positive). STS was requested in 73 patients and 69/73(94.5%) tested positive. Tp-PCR was requested in 41 patients and 35/41 (85.4%) tested positive. DGM was performed in 13 patients and 5/13(38.5%) tested positive. Both STS and Tp-PCR were requested in 40 patients: 30/40(75%) tested positive for both, 6/40(15%) tested positive only for STS and 4/40(10%) tested positive only for Tp-PCR (one had PCR which was negative). One patient had positive Tp-PCR but no STS result available.
Discussion During a 12 month period 74 patients were diagnosed with primary syphilis. 40 had combined STS and Tp-PCR – within this cohort 10% (4/40) had confirmed primary syphilis due to Tp-PCR as STS was negative and DGM was either negative or not tested. The addition of Tp-PCR provided an opportunity for early confirmation of syphilis.

P012 HIGHLIGHTING CLINICAL NEED IN DIAGNOSING MYCOPLASMA GENITALIUM INFECTION: USE OF A MODIFIED DELPHI APPROACH TO OBTAIN A UK PERSPECTIVE

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10.1136/sextrans-2017-053232.58

Introduction Despite *Mycoplasma genitalium* (MG) being increasingly recognised as a genital pathogen in men and women, commercial testing has only recently become available. The opinion of sexual health clinicians and allied professionals was sought on how MG testing should be used.
Methods 32 consensus statements were developed by an expert group and circulated to clinicians and laboratory staff who were asked to evaluate their level of agreement with each statement; 75% agreement was set as the threshold for defining consensus for each statement. A modified Delphi approach was used and high levels of agreement obviated the need to test the original statement set further.
Results 60 respondents returned questionnaires, most (48) being sexual health consultants. More than 10% of UK GUM consultants therefore responded. 27 (84.4%) of the statements exceeded the 75% threshold for consensus. Respondents strongly supported MG testing of patients with urethritis or PID, or unexplained persistent vaginal discharge, or post-coital bleeding. Fewer favoured testing patients with proctitis and support was divided for routinely testing chlamydia-positive patients. Testing sexual contacts of MG-positive patients was supported, as was a test of cure for MG-positive patients by most respondents, although agreement fell below the 75% threshold. Respondents agreed that all level 3 services should have access to testing for MG (98.3%).
Discussion There was strong agreement for having MG-testing available for specific patient groups, which may reflect concern over antibiotic resistance and the desire to comply with clinical guidelines that recommend MG testing in sexual health clinic settings.

P013 THE INTRODUCTION OF PHARYNGEAL CHLAMYDIA AND GONORRHOEA SAMPLING IN A YOUNG PERSONS' CLINIC TO ASSESS FOR THE POSSIBILITY OF PHARYNGEAL ONLY INFECTION THAT WOULD HAVE OTHERWISE BEEN MISSED

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Introduction Prior to April 2016 the policy in the clinic was to 'Consider taking a pharyngeal Chlamydia and Gonorrhoea swab in conjunction with exposure, history and symptoms' in heterosexual males and females. However, in practice pharyngeal swabs were almost never taken from heterosexual patients

and only routinely taken from men who have sex with men (MSM). Recent studies suggest that gonorrhoea and chlamydia infections are being missed by taking vulvovaginal and urethral samples only. Therefore, it was decided to take throat swabs for chlamydia and gonorrhoea from all patients aged 20 and under that attended the dedicated Young Persons' Clinic for one year. The findings so far will be presented here.

Results A total of 225 YPC attendees had a throat swab taken between April 2016 and February 2017. Twenty-five out of 225 patients (11%) were found to have pharyngeal chlamydia or gonorrhoea. Five patients had pharyngeal chlamydia and twenty had pharyngeal gonorrhoea. A significant number, fourteen of the twenty-five (56%), had pharyngeal chlamydia or gonorrhoea only with no genital infection. Gonorrhoea was detected in twenty patients' throats and chlamydia in five. Pharyngeal cultures were taken from eleven out of the twenty gonorrhoea patients, three of which were macrolide resistant and two macrolide intermediate.

Discussion Prior to the study throat swabs were not routinely being taken from heterosexual patients. More than half of patients with pharyngeal infection had no genital infection and would not have received treatment under the current clinic guidelines. These are significant findings which may lead to a change in practice in the service.

P014 DOES SEPARATION OF HIV AND SEXUAL HEALTH SERVICES AFFECT THE MANAGEMENT OF STIS IN PEOPLE LIVING WITH HIV?

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10.1136/sextrans-2017-053232.60

Introduction The presence of a bacterial STI increases the risk of HIV transmission. It is important that people living with HIV have easy access to STI treatment and that partner notification is robust. In our local area, HIV care is located and commissioned separately from the sexual health service. Does this affect STI treatment and partner notification?

Methods All HIV positive patients with a diagnosis of gonorrhoea, Chlamydia or new/infectious syphilis during 2015 were identified from laboratory results and computer records. Demographic details for each patient were recorded and the management of their STI assessed according to BASHH standards.

Abstract P014 Table 1 Impact of separation of HIV and sexual health services

Infection	Number of patients	Mean interval between test and informing patient (days)	Mean interval between informing patient and attendance for treatment (days)	Mean number of partners attending within 4 weeks [BASHH standard]
Gonorrhoea	24	14.6	4.5	0.375 [0.6]
Chlamydia	23	13.3	4.8	0.348 [0.6]
Syphilis	16	22.6	40.2	0.125 [0.4]

Results

Discussion Barriers to timely treatment included difficulty contacting patients, need to travel to a different service to obtain medication and difficulty arranging appointments at acceptable times. Particular delays were noted in the management of syphilis. Clarification of each service's responsibilities with regard to contact tracing could improve partner notification rates. Even when HIV and sexual health services are not jointly commissioned, it is essential that both departments work together to develop robust pathways for the management of STIs identified in people living with HIV.

P015 RECEIVING 1G AZITHROMYCIN AS PART OF MASS DRUG ADMINISTRATION (MDA) FOR THE CONTROL OF TRACHOMA IS ASSOCIATED WITH REDUCED GENITAL MYCOPLASMA GENITALIUMPREVALENCE

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10.1136/sextrans-2017-053232.61

Introduction Mass Drug Administration (MDA) with 1g oral azithromycin for ocular *Chlamydia trachomatis* (CT) infection, a key component of trachoma control, can concomitantly reduce genital CT prevalence. However, this dose is known to be sub-optimal for the treatment of genital *Mycoplasma genitalium* (MG) infection. Here we investigate factors associated with MG infection in pre- and post-MDA sample sets.

Methods Pre-MDA (T1) and 6 months post-MDA (T2) CT-negative self-collected vulvo-vaginal swabs from women attending three outpatient antenatal clinics (Honiara, Solomon Islands), were tested for MG infection using nucleic acid amplification. Logistic regression was used to determine factors associated with infection. Variables tested included: patient age, clinic attended, ethnicity, time spent in education, living in an urban or rural environment, marital status, living with spouse, presence of symptoms associated with a sexually transmitted infection (STI), having an STI in the last 12 months, current CT, Gonorrhoea or *Trichomonas vaginalis* infection, and at T2 only receipt of MDA dose.

Results MG positivity was found in 11.9% (95%CI: 8.3–16.6; 28/236) of women at T1 and in 10.9% (95%CI: 7.7–15.4; 28/256) at T2 (p=0.7467). The only factor associated with having an MG infection was history of not having received MDA with azithromycin at T2 (odds ratio 0.19, 95%CI 0.07–0.53, p=0.001).

Discussion Not having MG infection was associated with receiving 1g azithromycin as part of MDA for trachoma control six months previously. However there was no overall drop in population prevalence, indicating individual but not population benefits of MDA with regard to MG infection control.

P016 CLINICAL UTILITY OF A MYCOPLASMA GENITALIUM (MG) REFERRAL DETECTION ASSAY IN SELECTED SEXUAL HEALTH CLINIC ATTENDEES

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10.1136/sextrans-2017-053232.62

Introduction Routine testing for MG in the UK is limited by a lack of assays. New assays are becoming available, with many detecting antimicrobial resistance. We reviewed our use of an MG PCR test, and our treatment of MG, to inform a new, broader testing strategy.
Methods The clinical database was interrogated for all MG requests from November 2016-February 2017. Data collected: demographics, indication, test result, and treatment.
Results 85 samples were sent from 81 individuals: 79 (93%) were male, [39 (49%) MSM]. Indications for testing were: dysuria +/- discharge in 63 (74%), testicular/pelvic pain in 11 (13%), test of cure in 5 (6%), and contacts of infection in 3 (4%). 88% were tested on the second or greater attendance and 22 (26%) had already had received at least two antimicrobial treatments.

18/85 tests (21%) were positive for MG, of whom 17 (94%) had persistent or recurrent urethral discharge +/- dysuria. The remaining case was a female contact of recurrent NGU. Of the 17, 15 (88%) had previously been treated for NGU with azithromycin 1g (6, 40%) or doxycycline (5, 29%) or both (4, 24%). Eleven (61%) were treated with extended azithromycin (despite 5, (45%) having received azithromycin 1g already) and 4 (22%) with moxifloxacin.
Discussion Testing for MG in our service is performed mainly in men with persistent/recurrent NGU. Prevalence of MG in this selected group was high. Despite the likelihood of resistance, many patients received repeat courses of macrolides. Earlier testing for MG may reduce time with symptoms and improve antimicrobial prescribing behaviour.

P017 MANAGING MYCOPLASMA GENITALIUM IN CLINIC: DON'T FORGET THE PARTNERS

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10.1136/sextrans-2017-053232.63

Introduction There is increasing UK interest in Mycoplasma genitalium(MG) testing of clinic attendees where indicated. Partner notification(PN) is a crucial part of STI management but as yet no national performance standards specific to MG have been defined.
Methods Case note review of all MG cases at our clinic from December 2015 to November 2016. Data collected on the four PN outcomes outlined in the 2012 BASHH statement on PN for STIs.
Results 114 cases were identified. Mean age 28.5, 82(71.9%) male of whom 36(43.9%) MSM. The proportion of cases with a PN discussion documented (83.3% [95% CI 75.2–89.6]) and the proportion of cases with an outcome of agreed contact action(s) documented (78.1% [95% CI 69.4–85.3]) were both lower than the national standard of 97.0% ($p<0.0001$).

There were 0.22 (95% CI 0.17–0.28) contacts per index case whose attendance at a sexual health service for treatment was reported by the index case and 0.19 (95% CI 0.14–0.24) contacts per index case in which a healthcare worker verified treatment. Performance was lower than the national standard of 0.60($p<0.0001$), and inferior to local chlamydial and gonorrhoeal PN data, 0.6 and 0.5 contacts per index case reported treated respectively. Performance across all PN outcomes was worse for men than for women.
Discussion PN for MG at our clinic falls below local and national standards for other STIs. Contributory factors may include poor documentation, absence of national guidance for MG PN performance standards and lack of patients' appreciation of the importance of MG as an STI.

P018 UNIVERSAL TREATMENT – SHOULD WE REVIEW?

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Introduction Guidelines recommend epidemiological treatment of patients presenting as a contact of infection. This potentially reduces the prevalence of infection, reducing infectivity and reduces patient visits. Over prescription of antibiotics poses a threat of future resistance development and exposes the patient to unnecessary treatment. An audit was carried out to determine if any themes could be identified to indicate a likely positive result in contacts.
Methods We audited asymptomatic contacts of chlamydia and gonorrhoea (PNC/PNG) attending GU services at BartsHealth (February 2016 for 3 months). Data on gender, sexual orientation, contacts (regular or casual), infection site, time since sex with contact, HIV status, STI in previous year were collected. Testing by Aptima NAATS for chlamydia/gonorrhoea and gonorrhoea culture.
Results
Chlamydia 75 asymptomatic contacts (55 male/20 female). All treated as contacts. 25 had a positive result (34%). No factors could be associated with predicting a positive result, except a suggestion that a regular partner v casual partner. Gonorrhoea: 85 asymptomatic contacts (76 male/9 female). All treated as contacts. 27 had a positive result (32%). Being male >24years old/MSM/>5 partners (in 3m) and contact being a regular partner were suggestive of predicting a positive result.
Discussion The audit reinforces epidemiological treatment. Drawbacks of not treating include failure to return, onward STI transmission and inconvenience of re-attending. However, over 60% had potentially unnecessary treatment and with rapid turnaround of results (<2d), future universal treatment may need to be revised.

P019 ARE GPS TREATING GONORRHOEA APPROPRIATELY?

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Introduction Gonorrhoea continues to develop progressive antibiotic resistance. It is essential 1st line therapy is used wherever possible (intramuscular ceftriaxone with azithromycin 1g). GPs make an important contribution to gonorrhoea diagnosis and treatment (~5% of all diagnoses, of which ~40% are treated by GPs, 10% with recommended therapy).
Methods To assess local practice, the department of microbiology provided a database of all the cases of gonorrhoea diagnosed across our city Jan 15–Dec16. We reviewed cases diagnosed in primary care.

Results 1.7% (34/1,956) of all gonorrhoea cases were diagnosed in primary care. Median age 32 (range 18-66); 18 male, 16 female. 88% (30/34) were registered with sexual health (SH); 19 (56%) had attended for the management of episode in question (two of these had prior treatment with azithromycin 1g, or azithromycin/cefixime). Of the remaining 15 cases:

Abstract P019 Table 1 Are GPs treating gonorrhoea appropriately?

1st line therapy	Treated in primary care	2
	Referred and treated in level 2 service	2
Non-1st line therapy	Oral cefixime 400 mg + azithromycin 1 g stat	2
	Treated empirically at 1st visit (azithromycin 1g); advised level 3 but DNA	3
	Treated empirically at 1st visit (doxycycline 1 week);advised level 3, DNA	1
Advised to attend level 2/3 services – no record/DNA		3
2 no further information (1 surgery had closed)		2

100% of patients not receiving 1st line therapy had 'referral to SH advised' documented in the notes.

Discussion Knowledge of correct gonorrhoea management pathways was high. Oral cefixime/azithromycin is no longer recommended 1st line, however cure can be achieved at an individual level. It is likely some patients without record of attendance visited other services outside our area. The high number of female patients compared with our usual male to female ratio (10:1) raises doubts about false positive results in a low prevalence female population.

P020 COMPARISON OF THE APTIMA MYCOPLASMA GENITALIUM TMA ASSAY AND THE FASTTRACK DIAGNOSTICS (FTD) URETHRITIS BASIC ASSAY FOR DETECTION OF M. GENITALIUM IN GUM SPECIMENS

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10.1136/sextrans-2017-053232.66

Introduction Testing for *M. genitalium* in the UK is limited and detection has relied on realtime PCR assays. The Hologic Aptima *Mycoplasma genitalium* TMA assay for use on the Panther® system is now available. This study compared a commercial realtime PCR and the Aptima assay using stored clinical specimens.
Methods Clinical specimens (76 urines, 33 vaginal swabs, 2 rectal swabs, 1 pooled sample and 2 unknowns) from men with urethritis and women with pelvic inflammatory disease were tested for *M. genitalium* DNA using the FastTrack Diagnostics (FTD) Urethritis Basic assay. Residual specimen was then transferred to an Aptima urine tube and tested for the presence of *M. genitalium* ribosomal RNA using the Aptima TMA assay.
Results Of the 113 specimens tested, 24 (21%) were positive and 87 (77%) negative on both assays. There were two discrepant results (1.7%) in urine specimens that were positive on the Aptima TMA assay and negative on the FTD Urethritis assay. One was confirmed as positive by the Reference Laboratory using their in-house MgPa PCR, indicating a false negative result on the FTD Urethritis assay. The other discrepant result was low level positive on the Aptima TMA assay and negative at the Reference Laboratory.
Discussion 98% of samples gave concordant results, indicating that both assays are appropriate for use in clinical service. However, the additional positive detected by the Aptima assay, explained by detection of target in multiple copies in each bacterial cell, suggests that this assay is more sensitive.

P021 MYCOPLASMA GENITALIUM- TESTING AND TREATING IN A LEVEL 2 PRIMARY CARE SERVICE

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10.1136/sextrans-2017-053232.67

Introduction Mycoplasma genitalium (MG) is an emerging sexually transmitted infection causing up to 20% cases of urethritis in men and is a cause of PID. Most UK centres do not have access to MG testing. Locally we use an algorithm for testing and management of MG in collaboration with our level 3 service screening men with urethritis and women with PID.
Methods We reviewed the electronic Patient records of patients tested for MG from January 2016 to February 2017.
Results 66 patients were screened, all with genital symptoms. 35(53%) were male. 10/66(15.2%) patients tested positive for MG, 6(9.1%) males and 4(6.1%) females: median age was 34. The clinical symptoms were: 4/66(6.1%) -penile discharge, 4/66(6.1%)-long history of increased vaginal discharge, 1/66 (1.5%)-haematospermia, 1/66(1.5%) penile sores. 8/10(80%) were treated with 1st-line treatment (extended course of Azithromycin) in our primary care service while 2/10(20%) were referred to Level 3 service for assessment and treatment. Partner notification was done and documented in 50% of the positive cases but interestingly none of the 10 patients attended for test-of-care as advised.
Discussion We have shown that MG testing and treatment is feasible in a level 2 primary care setting in collaboration with level 3 services and that MG prevalence is high in symptomatic patients using this service.

P022 PHARYNGEAL GC: MAINTAINING STANDARDS IN MANAGING A SILENT INFECTION

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Introduction Our local area has the UK's highest prevalence of gonorrhoea. Pharyngeal infection is commonly asymptomatic, thereby acting as a reservoir of undiagnosed infection. Development of antimicrobial resistance continues to be a challenge to preserving sensitivity to current first-line treatment. Aim: To assess the management of pharyngeal gonorrhoea at an inner city sexual health centre with reference to BASHH 2011 guidelines.

Methods All cases of positive pharyngeal NAATs dating from 1st July 2014, to 1st August 2016, were identified from the clinical records portal and a case-note review completed.
Results 219 cases were included in the final data analysis - median age 33 (range 19–58). 131/219 (60%) lone pharyngeal gonorrhoea cases were identified. 194/219 (95%) were MSM. 89/131 (67%) pharyngeal cultures were obtained: (16%) positive for *Neisseria gonorrhoea* – 9/16 demonstrated some antimicrobial resistance. Only 8/131 (6%) had a sore throat documented at screening. 205/219 (94%) received treatments in clinic (14 patients lost to follow up). Of those treated 113/205 (55%) received a test of cure with 100% negative NAATs. All patients receiving 2nd line treatments were clinically justified. 1 patient was diagnosed HIV+ within 6 months of pharyngeal gonorrhoea treatment.
Discussion The majority of infections were asymptomatic (94%) demonstrating validity of on-going triple site screening. The low sensitivity of positive pharyngeal *N.gonorrhoea* cultures (16%) reinforces importance of pharyngeal NAATs for detection of infection and review of culture sampling techniques. A low rate of TOC reflected the difficulties in completing patient follow up seen in our clinic population

P023 INVESTIGATING THE CLINICAL VALUE OF TREPONEMA PALLIDUM PCR WITHIN A UK GUM CLINIC

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10.1136/sextrans-2017-053232.69

Introduction Syphilis is a multistage STI caused by Treponema pallidum. The classic lesion of primary syphilis is a chancre – a single, painless, indurated ulcer with a clean base. The number of cases is on the rise, and it has been historically difficult to diagnose due to its variable presentation, requiring clinical correlation and multiple investigations. PCR use has increased recently in investigation of these ulcers. However, how crucial is PCR testing in primary syphilis, when cheaper investigations can lead to a diagnosis?
Methods Investigation results were collected from 58 patients presenting between January and December 2015 who were treated for primary syphilis, including presentation, serology and PCR status. How they were diagnosed as having primary syphilis was noted and whether this was on presentation, follow up or via PCR.
Results 47 patients had a positive PCR, 11 patients had a negative PCR but were treated for primary syphilis. We found 3 patients would have not been picked up as having primary syphilis if there was no PCR performed. The sensitivity and specificity of Treponema pallidum PCR was 81% and 100% respectively.
Discussion PCR was essential in diagnosing 3 patients with syphilis who would have been missed, therefore PCR is a crucial tool in contributing to the diagnosis of primary syphilis. The potential implications of missing syphilis diagnosis are serious, as patients can develop progressive disease and unknowingly affect sexual partners.

P024 REDUCING REPEATED CHLAMYDIA AND GONORRHOEA INFECTIONS

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10.1136/sextrans-2017-053232.70

Introduction The role of Sexual Health Services (SHS) is not only to treat sexually transmitted infections (STIs) but also to reduce repeat infection through appropriate antimicrobials, health education and partner notification (PN). We reviewed the management of patients with repeat infections.
Methods A retrospective case-note review of patients attending the SHS with more than one episode of chlamydia and/or gonorrhoea, July 2015 – June 2016.
Results 156 patients were identified of which a random sample of 30 (20%) were reviewed. All were male; median age 29.5 (range 21-58). 70% (21) were MSM, 23% (7) heterosexual, 7% (2) bisexual. 30% (9) were HIV positive. Risk-factors for unsafe sex (e.g. substance misuse/sex-work/mental-health diagnosis) were noted in 77% (23). 77% (23) had 2 infective episodes; 23% (7) had 3 episodes. Of the 67 infective episodes all were treated appropriately; 40% (27) were treated the same day, 9% (6) within 1-week, 24% (16) within 2-weeks, and 22% (15) within 2–4 weeks. Patients reported 1–100 partners in the 6-months prior to review. 73% (48) saw a health advisor (HA); in the remaining 28% the most common reason for not seeing a HA was being managed in non-sexual health clinics e.g. PEP/HIV-research/general HIV. PN was undertaken in 82% (55) of episodes although only completed in 52% (35) largely due to untraceable partners.
Discussion Focusing on addressing risk factors for unsafe sex may facilitate a reduction in repeat STIs. While most patients were able to access HA support, referral pathways from non-SHS clinics need improving. PN remains challenging in the context of multiple casual partners and novel strategies such as electronic PN should be urgently explored.

P025 ACCURATE CULTURES FOR GONORRHOEA. HOW DO COMMUNITY SERVICES AND SECONDARY CARE COMPARE?

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10.1136/sextrans-2017-053232.71

Introduction BASHH guidelines emphasise the importance of accurate cultures in the diagnosis and management of gonorrhoea. This audit's aim was to establish if there was a measurable difference in the positive culture yield between community and secondary care services in the months following a change in contract which has moved a proportion of walk in patients from secondary care to the community setting.
Methods Relevant databases were searched for gonorrhoea patients after 1st October 2017 when the service was changed. A retrospective audit of the notes was then carried out to establish the rates of positive NAATS tests and positive culture yield and compared the two services.

Results In secondary care 25 patients (20 men & 5 women) were treated for gonorrhoea over two months. In these patients 22 had a positive NAATs test, of these 17 had a positive culture giving a positive culture yield of 77.2%.

In comparison the community service identified 10 patients in the first month of the new contract with a positive NAATs test, of these 9 had a culture. 1 culture was positive giving a NAATs/culture concordance rate of 11.1%; this is to be re-audited by the community service.

Discussion Accurate cultures are vital for the treatment of gonorrhoea, particularly in areas where antibiotic resistance is high. Appropriate storage and prompt processing is important to ensure the viability of these tests. This audit raises a question about viability of *Neisseria gonorrhoeae* during transfer from community settings to the central hospital laboratory.

P026 NEISSERIA GONORRHOEAE (GC): CHANGING PATTERN OF ANTIBIOTIC SENSITIVITY AND PERSISTENCE OF DNA DETECTION 2007 – 2016

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10.1136/sextrans-2017-053232.72

Introduction Nucleic acid amplification testing (NAAT) is used in GUM clinics to diagnose GC infection; however its in-built sensitivity potentially detects DNA from non-viable organisms following successful treatment. BASHH guidelines stipulate that test of cure with NAAT (TOC) should take place 2 weeks post-treatment.

This study aims to determine whether this is an adequate time interval to perform TOC. We also analysed the changing pattern of antibiotic sensitivity between 2007 – 2016.

Methods All GC cases at our clinic between 01/01 and 30/06 in 2007–2016 were identified, assessed for antibiotic sensitivity and analysed for TOC data from 2013–2016.

Results Of 131 cases in 2016, culture and sensitivities were available for 80, with TOC in 63.

Abstract P026 Table 1

Susceptibility to Antibiotic groups	2007 (%)	2009 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	2016 (%)
Fully sensitive to antibiotic testing panel	46	67	59	49	79	59	43	55
Reduced susceptibility to 1	27	15	20	38	10	20	23	23
Reduced susceptibility to 2	15	10	16	8	6	13	21	15
Reduced susceptibility to 3	12	2	5	3	2	8	5	6
Reduced susceptibility to 4								1

TOC was performed between 6 and 77 days post-treatment with mean, median and mode of 18, 14 and 14 days respectively.

Discussion No cultures were resistant to ceftriaxone. This is the first year a case has shown reduced susceptibility to 4 antibiotic groups. From 2015-2016 there has been an increase in GC fully sensitive to the antibiotic testing panel.

Our data supports BASSH guidelines for TOC 2 weeks post-treatment.

P027 RE-TESTING OF PATIENTS WITH POSITIVE CHLAMYDIA RESULTS IN PRIMARY CARE

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10.1136/sextrans-2017-053232.73

Introduction We aimed to establish how many young people (aged 15–24 years) diagnosed with genital Chlamydia infection in General Practice (GP) in 2015 in an inner city area had Partner Notification (PN) discussed with them and were offered repeat testing three-six months after initial diagnosis in line with BASHH guidelines.

Methods We identified young people with positive Chlamydia diagnoses made in GP in 2015 by searching the Chlamydia screening dataset from the hospital laboratory. We cross referenced with subsequent data sets for the year 2015 onwards to see if/when the patient was retested and where they were re-tested. For those re-tested in local GU clinics, we checked their records for evidence of PN initiated in primary care.

Results Preliminary data from January – June 2015 shows that sixty nine 15–24 year olds were diagnosed with Chlamydia in GP; 11 re-tested within six months, seven of these between one and three months post-initial infection of which one was positive. Three of the 11 re-tested in GU clinics; two of these reported PN initiated by GP.

Discussion Results so far show less than 1 in 5 young people diagnosed with Chlamydia in GP are being re-tested appropriately. It is possible that patients are travelling outside the area for re-testing and are missed by our sampling. Recommendations should include routine recall in GP for re-testing after three months to increase re-test rates.

P028 CHARACTERISING NEISSERIA GONORRHOEAE (NG) INFECTIONS AND TREATMENT IN A LARGE, URBAN COHORT

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10.1136/sextrans-2017-053232.74

Introduction Better detection and more frequent testing may explain increases in NG. We wished to characterise patients attending our clinics with NG, and audit management against BASHH standards.

Methods 300 sequential NG patients attending in 2016 were reviewed. Data collected: demographics, NAAT/culture positivity (per site), antimicrobial treatment and resistance, and test of cure (TOC).

Results Mean age was 34 (17–65); 92% male; 75% white; 86% MSM. 415 site specific infections captured. Site distribution by NAAT, culture concordance/sensitivities, and TOC are presented below:

Abstract P028 Table 1 Gonorhoea infections

	Sexuality			Culture results			Test of Cure	
NAAT+ by SITE	MSM	Hetero – Male	Hetero – Female	Cultures taken	Culture negative	Cipro-floxacin resistance	TOC Done	TOC Failure
VVS	NA	NA	7% (21/300)	76% (16/21)	19% (3/16)	7.6% (1/13)	76% (16/21)	0% (0/16)
Urethra	42% (126/300)	7% (21/300)	NA	90% (132/147)	3.7% (5/132)	33% (43/127)	53% (78/147)	2.6% (2/78)
Pharynx	37% (111/300)	0.7% (2/300)	1% (3/300)	68% (79/116)	51% (37/72)	43% (18/42)	66% (77/116)	5.2% (4/77)
Rectum	43% (128/300)	0.3% (1/300)	0.7% (2/300)	63% (83/131)	12% (10/83)	48% (35/73)	65% (85/131)	3.5% (3/85)

75% NAAT+ patients (310/415) had cultures performed. There was one case of ciprofloxacin and azithromycin resistance (MSM). 96% (287/300) received ceftriaxone plus azithromycin. Reasons for alternatives related to penicillin allergy. Median time to treatment 0 days (0-45d). 63% (189/300) attended for TOC (median time: 21d (7-188d)) and 94% (177/189) patients tested negative. Failed TOC was due to reinfection in 92%.

Discussion Our clinics maintain reasonable adherence to BASHH standards. Cephalosporin resistance was not observed. TOC times can be lengthy.

P029 AUDITING GONORRHOEA TREATMENT AND ANTIBIOTIC SENSITIVITY

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10.1136/sextrans-2017-053232.75

Introduction With diagnoses of Gonorrhoea on the rise and increased rates of resistance being reported, nurses carried out and audit to establish the level of compliance with current British Association of Sexual Health and HIV guidelines in relation to the treatment of patients diagnosed with GC and to analyse antibiotic sensitivity.

Methods Retrospective case note review of episodes coded B was carried out looking at age, ethnicity, sexual orientation, co-infections, treatment, resistance, number of partners in past 3 months, test of cures and follow up serology.

Results 69 cases reviewed, 33 MSM, 32 heterosexual, 4 bisexual. 10 patients were known HIV positive, 12 patients had 1 other co-infection, 4 had 2 other co-infections.

66 (96%) treated with first therapy of Ceftriaxone 500mg IM/Azithromycin 1G, 19 of these were also given Doxycycline 100mg twice daily for 1 week. 2 (3%) treated with Ceftriaxone 500mg IM/Doxycycline 500mg twice daily for 1 week. 45 (65%) fully sensitive to recommended antibiotics 13 (19%) reduced sensitivity to 1 antibiotic group 8 (11%) reduced sensitivity to 2 antibiotic groups. 4 (5%) reduced sensitivity to 3 antibiotic groups Our 5 cases of high level Azithromycin resistance were included. No cultures were resistant to Ceftriaxone

Discussion Treatment and management was in line with BASHH guidelines, it also highlights the developing problem with resistant infection, the importance of monitoring antibiotic sensitivity and effective partner notification in the effort to treat the infection adequately and reduce risk of transmission.

P030 MANAGEMENT OF RECTAL CHLAMYDIA IN AN URBAN SEXUAL HEALTH CENTRE

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10.1136/sextrans-2017-053232.76

Introduction We reviewed management of rectal chlamydia in our clinic and adherence to 2015 BASHH audit standards.

Methods Electronic patient records of 100 consecutive patients diagnosed with rectal chlamydia prior to 31 July 2016 were reviewed with respect to gender, sexuality, HIV status, symptoms, STI screening, treatment, test of cure (TOC) and partner notification (PN).

Results 64% were female (all heterosexual). 94% males were MSM; 18% were HIV positive. 1 male presented with rectal symptoms (pain). 23% patients had other genital symptoms. 76% were asymptomatic. 71% had concomitant STIs (including chlamydia at other sites). 90% received doxycycline 100mg bd for at least 1 week. 24% were treated with azithromycin before being recalled for doxycycline. Reasons included; not initially tested for rectal infection, attendance as a contact, initial treatment for presumed GC. All patients were advised to attend for TOC; 58% attended. All TOC were negative. All HIV positive patients were tested for LGV (1 positive). 1 MSM with rectal pain was not tested for LGV but subsequent TOC was negative. 36% received written information. PN was performed in 99% of cases with 81% of traceable contacts reported as attended and 47% of contacts being verified as attended.

Discussion High numbers of patients were issued with azithromycin as initial treatment requiring recall for doxycycline. This is concerning, particularly in an era of increasing antibiotic resistance. Education sessions have been provided, highlighting the importance of sexual history taking and use of doxycycline as first line chlamydia treatment where rectal infection is possible.

P031 EPIDEMIOLOGICAL STUDY ON SYPHILIS DIAGNOSES AT A LOCAL GENITOURINARY CLINIC (GUC)

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10.1136/sextrans-2017-053232.77

Introduction In 2015 our country reported 11.5 confirmed syphilis cases per 100 000 population, which is one of the highest rates in Europe. The objective of our study was to analyse the epidemiological characteristics of patients diagnosed with syphilis.

Methods A retrospective analysis of medical records of patients attending the local GUC with a diagnosis of syphilis from 2002–2015 was carried out. Data concerning patient demographics (age, gender and sexual orientation), year of diagnosis, syphilis stage, treatment regime, HIV/STIs co-infections, partner notification and follow up were recorded.

Data collected was inputted in an excel database.

Results In the study period a total of 291 patients were diagnosed with syphilis. 82.6% were males (n=238); 48.6%(n=143) were MSM and 5.2% (n=5) bisexual men. Syphilis was diagnosed in the primary stage in 11.3% of patients, secondary in 9.6%, early latent in 30.9% and late latent in 47.4%. All patients with syphilis were tested for HIV and 16.1% (n=147) resulted HIV positive, 74.5% of them (n=35) were MSM. Partner notification was not possible and/or not reported in 40.5% (n=118) of patients. In 21% (n=61) of cases, it was not possible to establish whether the treatment was successful because these were lost to follow up.

Discussion As the syphilis rates continue to rise so rapidly, it is very important to have robust mechanisms in place to limit spread such as proactive recall for treatment and follow up and education and support regarding safer sexual practices.

P032 CHARACTERISTICS OF A HIGH SYPHILIS INCIDENCE COHORT IN AN INNER-CITY LONDON CLINIC

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10.1136/sextrans-2017-053232.78

Introduction Syphilis cases continue to increase in London. We aimed to investigate the characteristics and risk factors of patients diagnosed with syphilis at our centre.

Methods Retrospective case note analysis of all syphilis cases diagnosed in our sexual health clinic in 2016.

Results 56 cases were identified; mean age was 42 (range 16–69 years), with 80% male. The two commonest ethnicities were Black Caribbean (20%) and White Other (20%). 18% were HIV positive, and 18% had concomitant STIs, with one new HIV diagnosis. 26% had been treated for syphilis previously.

Just under a third of patients were symptomatic, the rest being identified through routine screening in clinic or through online testing. Just over a fifth of the cases (12/56) were primary syphilis, with secondary syphilis diagnosed in 7% of patients. All primary and secondary syphilis cases occurred in MSM, and there was a correlation with reported chemsex, with 38% prevalence.

Two of the patients were vulnerable, one being a vulnerable child aged 16. One of the patients was on PREP.

There were 21 cases in heterosexual patients, all were late latent syphilis. Heterosexual men were older (mean 50 years); most heterosexual patients came from regions with high syphilis rates and endemic treponematoses.

Discussion There is high ongoing transmission of syphilis in MSM in our cohort, linked to risky sexual practices and drug use. Increased awareness of syphilis symptoms might facilitate earlier presentation to clinics. As many patients were asymptomatic, there is a pressing need for regular screening in high risk groups.

P033 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEAE

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10.1136/sextrans-2017-053232.79

Introduction We present a retrospective analysis of clinic performance in the 5 domains of management and treatment of Neisseria gonorrhoeae (GC) according to current British Association of Sexual Health and HIV (BASHH) guidelines.

Methods All cases of GC diagnosed at our clinic between 1st January and 30th June 2016 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared with data from the same clinic for the same six months (1st January to 30th June) in 2007-2015.

Results 87% of patients treated for GC were recommended to have a test of cure (TOC) (61% had a TOC.). 100% of with GC were screened for Chlamydia trachomatis or received presumptive treatment for this. 88% of patients with GC had partner notification carried out. 56% of patient's received written information about GC. 97% of patients with GC received 1st line treatment, or the reason for not doing so was documented.

Discussion We have demonstrated consistent improvement in 2 of the 5 domains compared with previous years' data. Recommending a test of cure, partner notification and offering patient information leaflets have decreased over the last year. To address this, teaching sessions were carried out and a quality improvement project to ensure patient information leaflets are offered is underway.

Further staff training and awareness of management of N. gonorrhoeae will be addressed on a regular basis and a re-audit is recommended next year.

P034 ASSOCIATION OF MYCOPLASMA GENITALIUM AND PERSISTENT ABDOMINAL PAIN- WHAT SRH DOCTORS UNDERTAKING ULTRASOUND NEED TO KNOW?

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10.1136/sextrans-2017-053232.80

Introduction The 2016 European guideline on Mycoplasma Genitalium (MG) states that significant association is found between MG and pelvic inflammatory disease (PID). MG is diagnosed through nucleic acid amplification testing. The aim of this study was to find out about the importance of testing for MG in patients with persistent abdominal pain.

Methods It was a retrospective analysis of patients who were tested for MG in Sexual and Reproductive healthcare (SRH) consultant ultrasound clinic over a period of 17 months. The inclusion criterion for testing was persistent symptoms after PID treatment.

Results 9 patients were tested for MG in consultant led SRH ultrasound clinic. All were initially treated by other clinicians for PID with standard treatment but did not respond and were referred to SRH ultrasound clinic to exclude other pathology. Ultrasound for all of the patients was normal with no adnexal masses or free fluid. Pregnancy test was done in all cases and it was negative; all patients were also negative for chlamydia and Gonorrhoea. MG testing was done in all 9

cases and 2 came back positive (22%). Both were treated with Moxifloxacin 400mg OD for 10 days.
Discussion This small study shows that there can be an association between persistent abdominal pain and MG. SRH doctors who are undertaking ultrasound on a routine basis should consider possibility of MG testing in patients with persistent abdominal pain. More research is needed in this area to establish a routine testing for MG in a patient with abdominal pain.

Contraception and Reproductive Health

P035 QUICK STARTING HORMONAL CONTRACEPTION AFTER USING ORAL EMERGENCY CONTRACEPTION: A SYSTEMATIC REVIEW

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10.1136/sextrans-2017-053232.81

Introduction Unprotected intercourse after oral emergency contraception (EC) significantly increases pregnancy risk. This underlies the importance of promptly starting effective, ongoing contraception – known as 'quick starting.' However, theoretical concern exists that quick starting might interact with EC or hormonal contraception (HC) potentially causing adverse side effects.
Methods A systematic review was conducted, evaluating quick starting HC after oral EC (levonorgestrel 1.5mg [LNG] or ulipristal acetate 30mg [UPA]). PubMed, EMBASE, The Cochrane Library, ICTRP, ClinicalTrials.gov and relevant reference lists were searched in February 2016. A lack of comparable studies prevented meta-analysis.
Results Three randomised controlled trials were identified. Two biomedical studies suggested HC action was unaffected by quick starting after UPA; one study examined ovarian quiescence (OR: 1.27; 95% CI 0.51 to 3.18) while taking combined oral contraception (COC). Another assessed cervical mucus impenetrability (OR: 0.76; 95% CI 0.27 to 2.13) while taking progestogen-only pills (POP). Quick starting POP reduced the ability of UPA to delay ovulation (OR: 0.04; 95% CI 0.01 to 0.37). Side effects (OR: 1.22; 95% CI 0.48 to 3.12) and unscheduled bleeding (OR: 0.53; 95% CI 0.16 to 1.81) were unaffected by quick starting COC after UPA. Another study reported higher self-reported contraceptive use at eight weeks among women quick starting POP after LNG, compared with women given LNG alone (OR: 6.73; 95% CI 2.14 to 21.20).
Discussion Limited evidence suggests quick starting HC after UPA does not reduce HC efficacy, however it reduces UPA efficacy. Consequently, women should delay starting HC after UPA.

P036 IMPROVING LARC UPTAKE: A RETROSPECTIVE STUDY INTO THE ROLE AND IMPACT OF ENHANCED SEXUAL HEALTH SERVICES IN COMMUNITY PHARMACIES

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10.1136/sextrans-2017-053232.82

Introduction Unwanted pregnancies and low uptake of LARC continues to be problematic in 15–44 year olds in an East London Borough. Between April 15 and March 16, 45 pharmacies were commissioned, as part of the local enhanced sexual health service (LES) to provide emergency hormonal contraception (EHC) and contraception advice with the aim of increasing LARC uptake in <25s and others at high risk of unwanted pregnancy. Pharmacies taking part in the pilot received PGD and safeguarding training and pathways into LARC were refreshed.
Methods Analysis of self-sample STI tests via the Doctor's Laboratory and consultations documented via PharmOutcomes, and corresponding search of PreView for attendances for contraceptive/LARC care during time period.
Results 35/45 pharmacies (77.8%) dispensed 324 Levonorgestrel (1500 microgram) doses to women resident in the borough >13 years (average age 24.9 years; range 14.2-49.6 years). 100% of <16s had Fraser competency assessed (4). 6.2% (20/324) women had >1 attendance for EHC. 16 women (4.9%) subsequently attended local CaSH/GUM services for LARC; 8 (2.5%) for implant; 4 (1.2%) for injectable; 4 (1.2%) for IUD.
Discussion Pharmacy delivered EHC and signposting to LARC services in primary and secondary care is feasible. There were limitations in the ability to gather data regarding women accessing LARC in primary care following contact with pharmacy so these numbers may under report the actual figures of those accepting LARC following pharmacy contact. Online booking systems should be accessible to pharmacists to facilitate LARC referral. Further work looking at acceptability of this strategy should be conducted.

P037 WHY DO WOMEN DISCONTINUE LONG ACTING REVERSIBLE METHODS OF CONTRACEPTION? – FINDINGS FROM AN INTEGRATED SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.83

Introduction Long acting methods of contraception, namely the progestogen only implant and the intra-uterine devices are reliable methods of contraception, favoured by commissioners of integrated sexual health. However in practice, a number of women discontinue these for a variety of reasons thus leading to reduced cost effectiveness. We aimed to determine the number of discontinuations among those who had them fitted in the integrated sexual health clinic and the reasons for doing so.
Methods Retrospective analysis of the case notes on the electronic database for all women who had an implant, copper intra-uterine device or the Mirena intra-uterine device during September 2014 was collected. Reasons noted by the clinician for removing the device and any adjuvant therapy that was prescribed was noted.
Results A total of 183 women had one of the three methods fitted during this period. Of these 36% had them removed after a median of 2.16 years. Of those who had the implant fitted, 49% had them removed after a median of 1.84 years. Vaginal bleeding was quoted as the reason for removal in 51% of the women. Of the 25% of the women who had the

Mirena IUD removed, vaginal bleeding was the reason in 44%. Variety of reasons were noted among the 36% of women who had copper IUD fitted.

Discussion Our findings has shown that vaginal bleeding was the predominant reason for discontinuation for the implant and Mirena IUD. This has shown that appropriate management of irregular vaginal bleeding may lead to longer retention of long acting methods of contraception.

P038 ULTRASOUND SCANNING IN GUM CLINICS – IS IT FEASIBLE; IS IT VALUABLE?

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10.1136/sextrans-2017-053232.84

Introduction With increasing financial constraint and commissioning pressures, GUM providers need to develop services to improve clinical care and cut costs. In order to provide fully integrated sexual health provision we introduced trans-vaginal ultrasound scanning to assess IUD/IUS position and placement as well as scanning for deep implants in August 2016 at a central London clinic.

Methods A member of staff trained in ultrasound was identified and a suitable portable machine sourced. From 11th August 2016, the new service was advertised to clinics within the trust and patients could be referred for assessment of coil/implant presence and position both for booked 'sessions' and on an ad hoc basis.

Results To 3rd March 2017, 127 TV scans have been performed. The indication for scanning was: 70 (55%) post insertion of inter-uterine contraception; 21 (17%) for lost threads; 9 (7%) bleeding problems and 27 (21%) other reasons.

5% (6/127) devices were identified as incorrectly positioned and could be changed at the scanning appointment. Only 1 patient required onward referral for a departmental ultrasound scan.

Discussion Ultrasound scanning in GUM clinics is feasible and has proven to be a valuable addition to current services offered. Consequently referrals for hospital based ultrasound scans have decreased, resulting in shorter waiting times for patients as well as providing a 'one stop shop' for patients.

P039 USER EXPERIENCE OF ONLINE BOOKING TOOL FOR LARC APPOINTMENTS

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10.1136/sextrans-2017-053232.85

Introduction Timely access to contraceptive counselling and increased use of LARCs is recognised as the key to avoid unintended pregnancy. In line with national SRH strategy, we aimed to improve access to LARC by supporting women to make informed choices and reducing barriers. The Sexual Health hub includes access to sexual health, well-being and contraception information, with positive promotion of LARCs, in one accessible site. Delivering pre-LARC counselling through online videos enables women to attend for a single focussed LARC fitting appointment.

Methods We recorded a number of metrics to assess uptake and impact on service provision and surveyed users to assess acceptability.

Results In the first 5 months we saw:

151% increase in visits to LARC self-help content and use of pre-consultation videos

11% of available bookable appointments made online, the majority out of hours

10% reduction in call volumes to services

Improved patient experience and choice as evidenced through user survey

- Very easy or easy to book an appointment online: 84%.
- Very easy or easy to find information and advice online: 92%
- Very likely or likely to recommend to a friend: 96%
- Very likely or likely to use the website again: 95%
- Positive free text comments

Discussion Our experience to date shows this approach is well received by patients who appreciate the flexibility it offers in their busy lives. It has also delivered efficiencies in administrative time, releasing staff for other tasks. We are monitoring the impact on uptake of LARC and anticipate data will further support this approach.

P040 MANAGING WOMEN REQUESTING PROGESTOGEN ONLY IMPLANT IN AN INTEGRATED SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.86

Introduction The progestogen only contraceptive implant is widely recognised as a reliable and cost-effective form of contraception. However, there is evidence to suggest that irregular or unpredictable bleeding is responsible for 60% of implant removals and another complication being that of deep implants. Continuous low-dose progestogen predisposes to breakthrough bleeding because uterine blood vessels proliferate and become disordered, with a 'leaky' basement membrane. The best approach is to provide oestrogen, usually in the form of the combined oral contraceptive pill (COC). We aimed to determine the proportion of women who have documented evidence of a palpable implant at the time of insertion and the proportion of eligible women with unscheduled bleeding offered the COC.

Methods A retrospective case note review was performed on the electronic database for the period between 1 July 2016 and 31 January 2017. First 100 women who requested implant fitting and the first 100 women who requested implant removal due to unscheduled bleeding were recruited.

Results Of the 100 women who had an implant fitted, 24% requested re-fitting. Palpable implants were documented in 76% of women. This was not documented in 24% of women, all of whom had another implant re-fitted. Of the eligible 100 women who requested removal for unscheduled bleeding and had no contra-indication for COC, only 49% had the offer of COC documented.

Discussion This review has shown the need to improve documentation of implant palpation and to offer COC to eligible women which will reduce unnecessary early removals, thus

ensuring cost-efficient provision of contraception. Other relevant demographic data will be presented.

P041 DISINTEGRATING SEXUAL AND REPRODUCTIVE HEALTHCARE? OUR PATIENTS' VIEWS

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10.1136/sextrans-2017-053232.87

Introduction The drive for integrated sexual and reproductive health services has improved access for women. However, councils in our area indicate Level 3 services will only provide initial contraceptive scripts, redirecting women to primary care services thereafter. We canvassed service users' opinions.
Method Women dispensed with pill/patch/ring/injection prescriptions during February 2017 were invited to complete an anonymous online survey.
Results The response rate was 46% (92 responses over four weeks). Half lived locally. A majority were aged 18–34 years (77, 84%), of white ethnicity (73, 80%) and in full-time employment (78; 84%). Most were GP registered (77, 84%). Most were pill users (62, 67%). Over half sought a repeat prescription (52, 57%), 24 (26%) were new starters and 18 (20%) requested a sexual health screen.

Two thirds (63, 69%) walked-in without an appointment. One third (32, 35%) stated they couldn't be seen at their GP. Ease of access was the main driver for attendance (76, 77%). Other key reasons for choosing our service: access to their method of choice (50, 54%); professional advice about methods (34, 37%); to ask sexual health advice (18, 20%); to receive STI screening (21, 23%). 78 women (87%) cited they had concerns about the council's proposal, with 69 (85%) stating access to primary care concerned them.
Discussion This survey highlights the value to patients of easy access to skilled professionals who provide comprehensive sexual and reproductive healthcare. Significant concerns were raised about this proposal, which ignores both the need and value women place on integrated services like ours.

P042 EMERGENCY, IMPLANTABLE & INTRAUTERINE CONTRACEPTION USE AMONG UNDER 18S IN AN INTEGRATED SEXUAL HEALTH SERVICE

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10.1136/sextrans-2017-053232.88

Introduction Teenage pregnancy can be reduced by timely access to emergency contraception (EC), implants, intrauterine (IU) devices and systems and quick-starting. Routine practice is to offer <18s all contraceptive methods, emergency IU contraception and quick-starting where appropriate.
Methods In the financial year 2015–16 there were 1975 attendances of 998 individuals <18 at a sexual & reproductive health service. Data was analysed using an electronic report.
Results 526 were White British (52.71%). 691 (69.24%) of <18s and 153 (79%) of <16s lived in the local authority area. 824 (82.6%) were female. 86 (10%) of first attendances in those <18 were for EC. 18 (20.1%) were <16, of whom 12 (67%) were quick-started a hormonal method.

15/193 (7.8%) of those 13–15 and 39/805 (4.8%) of those 16–17 years were fitted with an implant. 9/805 (1.1%) of those aged 16-17 were fitted with an IU device, no insertions in 13–15 years.

As a proportion of all ages IU contraception and implant insertions in <18s accounted for 9/1065 (0.85%) and 54/627 (8.6%) respectively.
Discussion The majority of <18 service users were local residents highlighting the importance of the availability of local services for people. Insertions of IU contraception in those <18 contributed a small proportion of total insertions undertaken. Further exploration of the acceptability and availability of IU contraception including EC for <18s is needed. We also suggest a review of those not quick-started after having EC to identify any barriers to access.

P043 CONTRACEPTIVE USE IN HIV POSITIVE WOMEN. ARE EFFECTIVE METHODS BEING OFFERED?

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10.1136/sextrans-2017-053232.89

Introduction British HIV Association (BHIVA) guidelines recommend that consistent condom use should be encouraged along with additional methods of contraception for women living with HIV. Highly active antiretroviral therapy (HAART) may reduce the efficacy of hormonal contraceptive.
Methods A retrospective chart review was carried out of all women under the age of 45 regularly attending the clinic (attended twice in the past year). Charts were reviewed to establish if the method of contraception used was discussed and documented within the past year, which method was being used and if there were any drug interactions.
Results A total of 145 female patients were identified. The method of contraception used was documented in 75%, as shown in the table. Of the women reporting no contraceptive use 14 were not sexually active. 124 (86%) patients were prescribed HAART. Of those patients who were prescribed HAART and hormonal methods of contraception, 2 potential drug interactions were identified of which 1 had been discussed with patient. From 2014–2016 29 patients became pregnant (those diagnosed through antenatal services were excluded) of which 19 where prescribed HAART.
Discussion Contraceptive methods should be discussed with HIV positive patients along with advice on consistent use of condoms in patients using hormonal methods of contraception and HAART. This will help prevent unplanned pregnancies as well as HIV transmission.

Abstract P043 Table 1 Contraceptive use in HIV positive women

Method of Contraception	Condoms	None	IUS	IUD	Hysterectomy/Sterilised	COC	POP	Implant	DMPA	Not documented
Number of Patients	46	36	8	3	6	4	2	1	2	37

P044 CONTRACEPTION CONTINUATION RATES IN THE UNDER 18S

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10.1136/sextrans-2017-053232.90

Introduction England has one of the highest teenage pregnancy rates in Europe. Although there is a wide selection of available contraceptives, they must be used consistently and correctly to prevent pregnancy.

There is limited data on contraception continuation rates in teenagers in the UK.

This audit aims to establish baseline continuation rates of the contraceptive pill/injection in <18's within a sexual health service.

Methods A retrospective audit on all 305 <18's started on the contraceptive pill/injection between Jan-March 2014. Continuation rates at 6 and 12 months were compared with the 2002 National Survey of Family Growth in the United States, standards cited by FSRH guidance.

Results The continuation rates of the combined oral contraceptive pill (COC) at 6 and 12 months were 59% and 44.9% respectively, the progesterone only pill (POP) were 37.3% and 23.6% respectively and the injection were 60% and 22.9% respectively.

Discussion The continuation rates were lower than the standard when compared with women of all ages. However, using age-adjusted rates, the COC continuation rate exceeded the standard by 3%, and the POP and injection rates were closer to the standard.

The COC had the highest continuation rate, suggesting the COC should be the method of choice in <18's.

Continuation rates dropped off more sharply in the first 6 months, suggesting this is the crucial time to remind, educate and engage with teenagers.

Continuation rates were higher in the section of the service with a dedicated vulnerable young persons' worker.

P045 VAGINAL INFECTIONS AND CONTRACEPTION – RESULTS OF A PATIENT QUESTIONNAIRE

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10.1136/sextrans-2017-053232.91

Introduction Bacterial vaginosis (BV) and candida are common problems among females using contraception. Associations between BV/candida and different contraception are described but not proven.

Aim(s)/objectives Establish knowledge of BV/candida among contraceptive users. Assess whether future research on BV/candida and contraception would interest patients.

Methods Surveys were distributed to females at two sexual health clinics and a student General Practice by staff not seeing patients. Responses were anonymous. Questions included knowledge of BV/candida, existing contraception, future contraceptive choices related to BV/candida and importance of research findings.

Results 298 completed a survey; 157/298 attending for contraception (90% using/starting a method), 141/298 attending for other sexual health reasons/GP consultation. Of 157 contraception patients, 22% were <20yrs, 96% were <35yrs. Overall, 40% had heard of BV and 39% of candida but in <20yrs, 26% had heard of BV, 17% candida. 47% were interested in outcomes of further research between BV/candida and contraception (30% neutral, 17% not interested), rising to 56% in those who had heard of BV and/or candida. Similar results were seen in surveys from 141 females not attending for contraception (58% interested if heard of BV and/or candida). 81% stated they would definitely/probably change from a contraceptive if it was proven to increase the development of BV/candida, and they acquired the infection.

Discussion There is patient interest in further research assessing associations between contraception and BV/candida, which would influence contraception choices. Patients preferred more knowledge on any links between contraceptive types and BV/candida rather than number of recurrences or persistence of symptoms.

P046 3 CASES OF TRICHOMONAS VAGINALIS INFECTION IN PREGNANCY

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10.1136/sextrans-2017-053232.92

Introduction Trichomonas vaginalis (TV) is not common in the UK, with under 7,000 cases in 2015. It is associated with poor pregnancy outcomes, and consensus on treatment pathways in persistent infection is needed. We present 3 cases of TV infection in pregnancy from 2 UK centres.

Methods A retrospective review of electronic case records was performed.

Results The median age was 21 years (range 20–31), with a median presentation at 13 weeks (range 7–22). Discharge was the main presenting symptom. Initial microscopy was performed in 2/3 and was positive; culture was positive in 3/3. All patients initially received oral Metronidazole 400mg twice daily for 5–7 days. At test of cure (TOC), one patient (Pt 1) remained positive, the second (Pt 2) did not attend, and the third (Pt 3) was negative. However, Pt 2 and Pt 3 re-presented after 5 weeks and 3 months, respectively: Pt 2 reported poor adherence; Pt 3 denied poor adherence or re-infection risk. All underwent further treatment. Pt 1 required 3 treatment courses before cure was achieved, with Metronidazole 800mg tds for 1 week. Pt 2 received 4 courses of oral or IV Metronidazole; she awaits TOC. Pt 3 received 5 different antibiotic courses, then opted to deliver and wean her baby before re-engaging with care. All denied re-infection risk after the second treatment.

Discussion Factors that contribute to persistent TV infection in pregnancy include re-infection, poor adherence, resistance, poor engagement, and concerns about teratogenicity. Further research is needed to identify the optimal treatment strategy.

P047 MANAGEMENT OF PATIENTS USING INTRAUTERINE CONTRACEPTION DEVICE- HOW A 3D SCAN CAN HELP TO MAKE A DIAGNOSIS?

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10.1136/sextrans-2017-053232.93

Introduction 3D scanning can enhance the ability of a clinician to make an accurate diagnosis. The aim of this study was to evaluate the usage of 3D scanning in making a correct diagnosis of uterine anomalies and location of intrauterine contraception (IUC).
Methods It was a retrospective analysis of patient's notes that had 2D and 3D ultrasound done in Sexual and Reproductive healthcare clinic over a period of 6 months. All patients who had ultrasound done in relation to coil were included. The exclusion criteria were when ultrasound was done in terms of pelvic pain or bleeding and patient was not using IUC.
Results 90 patients were included in the analysis and all of them had both; 2D and 3D ultrasound. 57% of patients attended clinic with lost threads. 13% had bleeding problems and 8% had unsuccessful removal/insertion previously.

On ultrasound examination, 88% had coil placed at fundal location and 7% had low lying coil. 5% of patients had myometrial penetration of coil. 38% of patients were reassured about coil location and in 35% of cases coil was either removed or replaced. Gynaecology referral was done in 12%. 1 patient was diagnosed with sub-septate uterus.
Discussion This study has shown that 3D scanning enhances the image quality by facilitating in the accurate location of coil especially in cases of myometrial penetration. It also helped in diagnosis of sub-septate uterus, which is not easily plausible with 2D scanning.

P048 ATTITUDE OF HEALTHCARE PROFESSIONALS' AND HEALTHCARE STUDENTS' ATTITUDES TOWARDS TEENAGE PREGNANCY AND PARENTING

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10.1136/sextrans-2017-053232.94

Introduction Britain used to be known for its high rates of teenage pregnancy. It was labelled a 'shameful record' by the Labour government and the Teenage Pregnancy Strategy was launched. Rates of teenage pregnancy are falling. 3.4% of babies born in 2015 were to mothers under the age of 20, compared with 10.3% in 1970. Teenage pregnancy is strongly associated with social disadvantage and health problems. Studies have been done into life outcomes of teenage parents but there is limited research about attitudes of healthcare professionals towards this group.
Methods An original 12 part questionnaire was designed to assess attitudes towards teenage pregnancy and parenting. 502 questionnaires were returned. A scoring system was devised (1–5) with 5 being a positive view and 1 being negative view using a Likert scale. Respondents could leave comments in the free text sections.
Results 55% of respondents think that teenage pregnancy is a public health problem. 18% had been affected by teenage pregnancy in their personal lives. 85% of respondents interact with teenage parents as part of their job role. 49% of HCPS would be happy discussing contraception with a patient of any age.

Improved access to contraception was the most favoured intervention to reduce teenage pregnancy followed by media campaigns aimed at teenagers.
Discussion Teenage pregnancy can be an emotive topic and it is important to be aware of the potential stigma teenage parents may receive. This research also showed some interesting differences between attitudes towards male and female teenage parents.

P049 EVALUATING THE USE OF LONG-ACTING REVERSIBLE CONTRACEPTIVES; WHAT CAN BE DONE TO IMPROVE UPTAKE?

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10.1136/sextrans-2017-053232.95

Introduction Despite an improvement in the rate of unplanned pregnancies in England, the problem persists, particularly in the teenage population, with a large proportion of these conceptions being attributed to contraceptive failure. The OCP and male condoms remain the most widely used contraceptives, which considering their dependence on user-compliance is worrying. Long-acting reversible contraceptives are an alternative with much lower failure rates, partially attributable to the removal of this concern.
Methods An audit was carried out at Wellfield Medical Centre in Manchester, one of the areas with persistent high teenage pregnancy rates.
Results A review of records highlighted that the OCP remained the most commonly prescribed contraceptive in women over the preceding year. LARC accounted for only 29% of the new prescriptions given to 15–24 year olds and 41% of under-35s, with LARC being favoured only in the older population.
Discussion This was in keeping with the literature, which suggested that social norms and negative experiences of friends and family are accountable, along with a lack of education of LARC compared with other methods. These findings indicate that an improvement in the awareness of safety and efficacy of LARC is necessary, particularly in this young population. This should be initiated in a practice context, but the wider reach of social media may be required to ensure an adequate impact. The skill and ability of providers to counsel women on LARC needs to be addressed, as does an increase in time available for counselling and detailed recording of these discussions.

P050 THE UPTAKE OF LARC'S IN ADDRESSING SUBSEQUENT UNPLANNED PREGNANCIES IN YOUNG WOMEN

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10.1136/sextrans-2017-053232.96

Introduction To decrease the number of subsequent unplanned pregnancies in young women presenting to one regional public health service and to note the barriers to the overall uptake of contraceptive options.
Methods Young mothers referred for antenatal care received consistent and regular education about contraceptive options. The young women attending were up to the age of 21 years. Contraceptive options that were utilised at the time of becoming pregnant consisted of combined oral contraceptive pill (COCP), condoms, withdrawal or none. The use of the Choices Contraceptive Chart aided in the process to support the efficacy of long acting reversible contraceptive methods (LARC).
Results Total number of births within this public hospital for 2012 – 13 combined was 4,494. Of this, 276 were to mothers 21 years and younger. Total number of births for 2014 – 15 combined were 5,488 with 240 to mothers 21 years and younger. Health care professionals (HCP) education and

beliefs, along with provision of LARC prior to discharge needs addressing.

Discussion Despite international evidence, which strongly suggests that the use of LARC's reduce unintended pregnancies and subsequent abortions, their use in Australia remains low. There is a need to address the barriers to increasing the use of LARC's in Australia, particularly by young women who are highly fertile & have unintended pregnancies. Use of COCP is higher in Australia than in other countries. Implants, injectable and IU devices, combined are still used by fewer than 10% of Australian women and their provision in general practice is low.

Electronic Patient Records and Information Technology

P051 EVALUATION OF THE ACCEPTABILITY AND IMPACT OF AN ONLINE BOOKING TOOL

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10.1136/sextrans-2017-053232.97

Introduction Finding smarter ways of working which meet the needs of increasingly IT-savvy clients and support their busy lifestyles is always a priority and provides an opportunity to innovate.

Informed by focus groups, we developed an on-line booking system, designed to be mobile-first, empowering people to book and manage their own appointments through a secure server.

Methods We monitored use of the online booking system and impact on DNA rates, as well as user acceptability, through online feedback and continued engagement with user focus groups.

Results In the first 5 months we have seen: Average 11% of all bookable appointments made on-line, with majority completed out of hours. 75+% users accessing from a mobile device. 10% reduction in call volumes to services, saving 213 hours of admin time. Improved patient experience and choice as evidenced through user survey: Very easy or easy to book an appointment online: 84%; Very likely or likely to use the website again: 95%. As yet DNA rates have been unaffected.

Discussion The ability to book and manage appointments online has been well received by users and has reduced administrative time. Further tweaks have included a 'text to cancel' system which we anticipate will have a positive impact on DNA rates.

Investigation of different uptake rates between services has led to shared learning and it is anticipated that the average uptake of bookable appointments made online will reach the target of 20% within the next 3 months.

P052 USING MODERN TECHNOLOGY TO IMPROVE THE MANAGEMENT OF INITIAL PRESENTATION OF HERPES SIMPLEX VIRUS INFECTION – COMMUNICATION WITH PATIENTS AND DELIVERING PCR RESULTS

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10.1136/sextrans-2017-053232.98

Introduction The first presentation of Herpes Simplex Virus (HSV) may be distressing, with severe symptoms and associated stigma pertaining to the diagnosis. Initial audit confirmed clinic staff were inconsistent with how the initial clinical diagnosis was relayed to patients, the amount of information given and how follow up and PCR test results would be provided. Best practice dictates that detailed information and uncertainties around diagnosis should be communicated.

Methods Staff training was delivered using workshop style sessions and local protocol changed to highlight '10 key points' to be communicated. An SMS used to deliver positive HSV PCR results was changed to include a bitlink to clinic website 'Genital Herpes' page and link to BASHH patient information leaflet. The automated results line was changed for PCR negative results, providing information for follow up if symptoms remained. A GP letter was created for PCR positives.

Results Audit cycles were comparable in gender, age distribution, HSV type and PCR negativity rate. There was a significant improvement in the number of patients who received written information ($p=0.0043$), discussion on PCR sensitivity ($p<0.0001$), discussion on disclosure ($p<0.0001$) and significant reduction positive PCR results with no record of result being given ($p=0.0091$). There number of patients requiring follow up appointment for same episode of HSV did not change.

Discussion Using modern technology can improve communication of important information to the patient and ensure the patient receives the result appropriately. Altering electronic resources can give more information and provide a back up when the diagnosis is unclear.

P053 TOGETHER IN ELECTRIC SCREAMS: THE FRUSTRATIONS OF GUM ELECTRONIC PATIENT RECORDS

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10.1136/sextrans-2017-053232.99

Introduction Many GUM clinics have shifted from paper to Electronic Patient Records (EPR). While paper has limitations, its natural functionality – e.g. free-form writing, sketching and page-turning – is intuitive and easy to exploit. EPR promises so much, but how easy or intuitive is it in current clinical GUM practice?

Methods A mixed methods paper survey asking GUM clinicians about the EPR they use.

Part one asked about usability and function with fourteen 7-point Likert-scale items. Part two guided respondents to describe qualitatively how EPR affected their sense of the clinical consultation.

Results Out of 33 surveys distributed, 28 were returned (85%) by mixed staff groups from 3 clinics using the same EPR.

Likert-scale items underwent chi-square analysis after collapsing responses into positive and negative groups. All 14 items were negatively skewed away from neutral; 8 of these were significant ($p<0.05$): history overview, accuracy with multiple visits, getting lost, mirroring clinical reality, use of graphics, amount of clicking, searchability and support of clinical practice. Further analysis will explore this deviation from neutral.

Qualitative responses described frustration, reduced competence/autonomy, interrupted flow, poor eye contact, poor

history overview, repeated questions - particularly with symptomatic patients or with multiple episodes of care.
Discussion There is dissatisfaction with this EPR system, both in the way it functions and its impact on the clinician-patient consultation. Further research is warranted to assess the extent of these issues with other GUM EPR systems, and to explore ways of engaging with clinical information that help rather than hinder clinical performance.

P054 2017 UPDATE OF DRUG INTERACTIONS DETECTED USING ELECTRONIC CARE RECORDS (ECR)

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10.1136/sextrans-2017-053232.100

Introduction In 2014 the pharmacy team completed an interaction screen of all HIV patients on a boosted antiretroviral (ARV) regimen using then recently launched NIECR. We concluded that there was a need for primary and secondary care teams to screen and manage drug-drug interactions (DDI). 56 patients in 2014 required urgent clinical intervention.
Methods In 2014 we reported on patients taking a boosted ARV regimen for DDI; we continued this work for all patients and this year we reviewed our interaction screening database, to assess the following: Interaction screen documented, Number of patients issued medication by their GP, Percentage of interactions identified.
Results 1093 unique patient records, 887 (81.2%) have a recorded H&C number and interaction screen. 468/887 patients (53%) are prescribed medication by their GP with no or no significant interactions. 235/887 patients (27%) are prescribed medication by their GP where an interaction is identified by the MDT and managed. 122/887 patients (14%) do not obtain any medication from their GP. 9/887 patients (1%) have opted out of NIECR. No patients required an immediate clinical intervention.
Discussion The number of patients prescribed medications by their GP has increased from 45% in our 2014 report compared with 79.3% in this review. There was a significant improvement in the latest review of interactions and no patients were identified with serious interactions. A medicines reconciliation and interaction screen before initiating/switching treatment and prior to a clinic review has enabled our cohort to avoid clinically significant DDI.

P055 USING THE ELECTRONIC PATIENT RECORD TO SUPPORT CAPACITY PLANNING BY LINKING NEED TO LEVEL OF SERVICE

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10.1136/sextrans-2017-053232.101

Introduction Planning service capacity is key to ensuring that sexual health services continue to be functional and sustainable. We have reviewed and categorised data recorded in our electronic records system and by categorising activity and then identifying appropriate staff level associated with that activity we can more effectively plan capacity.
Methods We established agreement about service activity and assigned these activities to the categories of: integrated sexual health 1 and 2, integrated sexual health 3, online and telephone. Using 2016/17 quarter 2 and 3 data we grouped individual attendance records to these categories. Our analysis, based on a combination of item of service, SHHAPT coding and prescription, allowed us to robustly assign attendance to category. This was then compared with the level of care and access clients actually received in terms of staff level, and the variations showing the potential for shift across levels was established. We then audited at patient record level to provide assurance about assumptions made in the categorisation process.
Results The results indicated that a significant percentage of clients currently being seen in a face to face setting are appropriate for online and telephone consultations. We further identified a number of clients seeing doctors who were appropriate to be seen by nurses, indicating further shift potential.
Discussion This approach informs service capacity plans and drives efficiency. The potential for capacity release is tangible and can be applied to other service requirements such as training and service development. We are developing a dashboard system for responsive monitoring.

P056 PROVIDING WRITTEN INFORMATION IN THE ELECTRONIC ERA – IS IT TIME FOR A RE-THINK?

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10.1136/sextrans-2017-053232.102

Introduction Recent BASHH guidelines state that patients should be directed to clear, accurate written or web-based information and this is often an auditable outcome. We stopped providing paper leaflets in 2016 as our electronic patient record (EPR) allows a link to web based patient information leaflet (PIL) to be sent by short message service (SMS). Our aim was to identify if this had improved uptake of written information.
Methods We identified 200 patients who received a positive chlamydia or gonorrhoea result and returned to clinic for treatment. Records were reviewed for offer and uptake of PIL.
Results 41 patients (20.5%) were sent a PIL link, 20 (10%) were documented to have declined and 139 (69.5%) had no documentation regarding PIL.
Discussion Provision of links to PIL was low in this patient group. This compares to our 2012 audit of chlamydia, a time of paper records, where 59% accepted a leaflet. Our EPR shows the link has been sent but requires free text to record offer or refusal, so the actual offer may have been higher and not documented. Half had the name of the infection specified in a results SMS and therefore many may have already sought web based information prior to treatment. Plans to improve our documentation of offer of PIL include consideration of a PIL link with the initial positive SMS. Patients are increasingly likely to access information online, sometimes prior to attendance and BASHH may wish to consider this in their guideline recommendations and auditable outcomes.

P057 TRENDS IN RECORDED ABORTIONS IN UK GENERAL PRACTICE – COHORT STUDY USING CLINICAL PRACTICE RESEARCH DATALINK (CPRD)

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10.1136/sextrans-2017-053232.103

Introduction Clinical Practice Research Datalink (CRPD) is a database of health records from participating general practices in the UK. Patients in the CPRD are broadly representative of UK population. We studied trends in recorded abortions between 2004 to 2014 in participating general practices in England and Wales.
Methods We created a cohort of females between ages of 15 to 44, registered with practices in England or Wales, during period 2004 to 2014. We identified abortions using Read codes. We removed records that were: misclassified, inaccurate in event and birth dates, and duplicates. We present trends in abortion data in women aged 15 to 44 in England and Wales using descriptive statistics and compared them with national data published by Department of Health (DH).
Results There were over 114,000 recorded episodes of abortion between 2004 and 2014, with almost 5 million women of target age groups in the cohort. There appeared to be a consistent, year-on-year decrease in crude abortions rates from 2004 to 2014 using abortions data recorded on CPRD. The rate of decrease is less marked in the same period using national data. The age group 20–24 had the highest rate of abortions in every year, which correlates with national statistics.
Discussion There are similarities and differences in abortion data between CPRD and DH which might reflect differences in the way data are collected and recorded. We suggest abortion records on CPRD need further work on data validation before conducting robust epidemiological studies.

HIV Prevention, PEPSE and PrEP

P058 DEMAND FOR PRE EXPOSURE PROPHYLAXIS FOR HIV (PREP) AND THE IMPACT ON CLINICAL SERVICES: SCOTTISH MEN WHO HAVE SEX WITH MEN (MSM) PERSPECTIVES

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10.1136/sextrans-2017-053232.104

Introduction Studies have assessed awareness and interest in taking PrEP but there is less data on ability and willingness to self-fund. Our aim was to assess how many eligible (high risk, PROUD study criteria) may want PrEP, how many ineligible (lower risk) MSM would be willing and able to self-fund and how PrEP may impact on risk taking behaviour.
Methods
Self-completed anonymous questionnaire Questions included sexual risk and risk frequency, willingness to take PrEP, income, willingness to self fund and impact on risk taking.
Results Of 377 participants, 81.5% were aware of PrEP. 53 (15.5%) were eligible, of whom 50 (94.3%) aware of PrEP and 50 (94.3%) likely to want it. Of those ineligible, 229 (80%) aware of PrEP and 171 (60%) likely to want it. The majority of men reported they would not be more likely to have condomless sex or increase partner numbers.
Discussion Levels of awareness of PrEP in our population were much higher than the 30% previously reported in Scotland. Previous studies showed 50% would be willing to take PrEP. In this study, 94.3% of the 15.5% of men eligible and 60% of those ineligible were likely to want it. This will have implications for discussions and monitoring. A systematic review of PrEP[6] found no difference in condom use or numbers of partners. Our study indicates that men believe that risk taking behaviour will likely not increase.

P059 DRUG-DRUG INTERACTIONS IN HIV PATIENTS TAKING PHARMACOKINETIC ENHANCERS

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10.1136/sextrans-2017-053232.105

Introduction Antiretroviral medications have the potential to produce serious drug interactions by interfering with the hepatic cytochrome P450 cascade. Ritonavir, a protease inhibitor, is a known CYP450 inhibitor that is commonly used in the treatment of HIV[1]. Iatrogenic Cushing's syndrome is caused by exposure to glucocorticoids and may be promoted by interaction with additional drugs that result in hypothalamic-pituitary adrenal axis suppression[2]. It is well documented in HIV patients receiving inhaled steroids in combination with a ritonavir-containing antiretroviral regimen[3]. Following one such severe drug-drug interaction in a patient, a clinical audit was conducted to identify potential drug-drug interactions in a HIV clinic at Beaumont Hospital, Dublin.
Methods 200 patients receiving Ritonavir were interviewed and screened for harmful prescribed and non-prescribed co-medications. Patients receiving regular steroid doses and Ritonavir were identified and all drugs were cross-referenced to the Liverpool Drug Interactions website to highlight any dangerous drug interactions.
Results 86% of patients had concomitant prescribed medications, three-quarters of which were undocumented. Furthermore, 45% of patients used regular over the counter-medication and 2.7% used recreational drugs. 8% of patients were flagged for potentially dangerous drug-drug interactions and of these, 15% contained steroids.
Discussion The interaction between corticosteroids and PIs is significant and deserves close attention and evaluation. Timely communication among all prescribing physicians for a given patient is indicated in order to proactively detect significant interactions before they manifest themselves clinically.

P060 DRUG RESISTANCE AMONG WOMEN ATTENDING ANTENATAL CLINICS IN GHANA

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10.1136/sextrans-2017-053232.106

Introduction Initial evidence from resource-limited countries using the WHO HIV drug resistance (HIVDR) threshold survey suggests that transmission of drug-resistance strains is likely to be limited. However, as access to ART is expanded, increased emergence of HIVDR is feared as a potential consequence. We have performed a surveillance survey of transmitted HIVDR among recently infected persons in the geographic setting of Accra, Ghana.

Methods As part of a cross-sectional survey, 2 large voluntary counselling and testing centres in Accra enrolled 50 newly HIV-diagnosed, antiretroviral drug-naïve adults aged 18 to 25 years. Virus from plasma samples with >1,000 HIV RNA copies/mL (Roche Amplicor v1.5) were sequenced in the *pol* gene. Transmitted drug resistance-associated mutations (TDRM) were identified according to the WHO 2009 Surveillance DRM list, using Stanford CPR tool (v 5.0 beta). Phylogenetic relationships of the newly characterised viruses were estimated by comparison with HIV-1 reference sequences from the Los Alamos database, by using the ClustalW alignment program implemented.
Results Subtypes were predominantly D (39/70, 55.7%), A (29/70, 41.4%), and C (2/70; 2, 9%). Seven nucleotide sequences harboured a major TDRM (3 NNRTI, 3 NRTI, and 1 PI- associated mutation); HIVDR point prevalence was 10.0% (95%CI 4.1% to 19.5%). The identified TDRM were D67G (1.3%), L210W (2.6%); G190A (1.3%); G190S (1.3%); K101E (1.3%), and N88D (1.3%) for PI.
Discussion In Accra the capital city of Ghana, we found a rate of transmitted HIVDR, which, according to the WHO threshold survey method, falls into the moderate (5 to 15%) category. This is a considerable increase compared with the rate of <5% estimated in the 2006–7 survey among women attending an antenatal clinic in mamobi. As ART programs expand throughout Africa, incident infections should be monitored for the presence of transmitted drug resistance in order to guide ART regimen policies.

P062 ACCESSING THE PREP POPULATION: WHAT IS THE BEST SERVICE MODEL?

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10.1136/sextrans-2017-053232.107

Introduction Pre-Exposure Prophylaxis (PrEP) is effective to prevent HIV infections. Optimal service models for delivering this intervention are as yet unclear. We looked at our dedicated PrEP clinic in East London to identify who was accessing our service.
Methods Retrospective case note review collected demographics, PrEP use, STI rates and 'chem' use from January to November 2016. Data was analysed with STATA.
Results 116 visits from 54 patients were returned with a median age 42 years (IQR 32 – 44.5). 90% were white. Of these 54 patients, only 27 started PrEP and engaged in care. For our population, there were lower than expected rates of STI's (6% for CT and 9% for GC – any site) and a median of 4 partners in the preceding 90 days; much lower than encountered in the PROUD trial. 40% (21/54) had used 'chems' at some point, with 21% (4/21) of those 'slamming' (using intravenously) in the last 3 months. Routine urinalysis showed 30% abnormalities, but no subsequent abnormal uPCR.
Discussion As the interest and use of PrEP grows, new service models may have to be developed to accommodate this population. We saw varying levels of engagement with patients who were predominantly white with low sexual risk. Young MSM were also underrepresented. Engagement with BME and MSM communities, along with drug services, may be needed to inform effective delivery of this intervention to those most at risk.

P063 PEPSE FROM THE EMERGENCY DEPARTMENT: REDUCING MISSED OPPORTUNITIES FOR PATIENT FOLLOW UP

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10.1136/sextrans-2017-053232.108

Introduction PEPSE is one method of reducing HIV transmission in higher risk groups. It is commonplace for PEPSE to be delivered from the Emergency Department (ED) out-of-hours. PEPSE delivered outside of GUM can be met with challenges in regard to follow up; resulting in missed opportunities for health promotion, education and STI testing.
Methods Retrospective case-note review of ED episodes from 1/4/2015–31/3/2016. Demographic information and data collected compared with audible outcomes (BASHH 2015 PEP guidelines).
Results 37 patient episodes identified; 97% male with a mean age 28.2 years. 86% of these episodes occurred out-of-hours with 84% receiving PEPSE within recommended indications (standard 90%). 81% of patients prescribed PEPSE had an HIV test within 72hours (standard 100%). In regard to follow up, 59% of all patients attended for STI testing (standard 90%). There was a 9% rate of STIs reported in those attending for follow up. 51% of all patients had an 8–12 week HIV test (standard 75%). There was 1 new HIV diagnosis reported. Introduction of an ED staff education programme and e-referral pathway has resulted in a 24% increase in patients attending for STI testing. In addition, 100% of patients using pathway had an HIV test within 72 hours and 100% of PEPSE prescriptions were within recommended indications.
Discussion Targeted quality improvement strategies can have a significant impact on PEPSE outcomes for higher risk groups. Improved follow up within GUM after PEPSE prescription in ED has increased opportunities for diagnosis and treatment of STIs, vaccine provision and patient education.

P064 AUDIT OF POST-EXPOSURE PROPHYLAXIS WITH ASSOCIATED RISK PROFILES AT THE GAY MEN'S HEALTH SERVICES, DUBLIN, 2016

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10.1136/sextrans-2017-053232.109

Introduction The incidence of HIV infection is rising in Ireland, reaching a rate of 10.6/100,000 people in 2015. MSM is the most common route of transmission, reported as 50.9% of new diagnoses. There is a comparative surge in requests for HIV post-exposure prophylaxis (PEP) in Gay Men's Health Services (GMHS), Dublin: 44% increase in 2016, vs. 2015. In 2016, a PEP proforma was devised for consistent clinical assessment of PEP requests and decisions.

Methods We performed a retrospective review of all PEP requests from June-December 2016, following the introduction of this proforma. We investigated exposure types, reported use of condoms, alcohol, drugs, and partners STI status. We assessed appropriateness of PEP decisions in accordance with national guidelines, and compared risk profiles to published findings from 56 Dean Street.
Results 116 PEP assessments occurred in this time, with the specific proforma. All were evaluated as appropriate for PEP. GMHS attendees had same median age (31 years) as those of Dean Street. However, GMHS attendees reported significantly elevated risks of no condoms used (73 vs 54%; p <0.0001), more recreational drugs (30 vs 20%; p = 0.01), with an additional 13% using both drugs and alcohol. GMHS attendees reported more IAI, and significantly less group sex activity (3.5 vs 11%; p =0.02). Partner's viral or bacterial STI status was rarely known.
Discussion PEP is appropriately assessed and provided for GMHS attendees. High risk sexual behaviours are common, requiring comprehensive HIV prevention strategies for the continuing epidemic.

P065 THE GMI COMMUNITY COACHING MODEL – COACHING HIV SELF-TESTING AND SELF-SAMPLING WITHIN HIGH RISK MSM

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Introduction In light of moves towards online provision of HIV services, e.g. self-testing, or online self-sampling, the GMI Partnership wanted to understand whether there was a way in which community based organisations could support and incorporate trends towards online provision of services, as well as understand the knowledge of at risk communities in light of changes, through the provision of community coaching on self-testing and self-sampling. The GMI Partnership provides sexual health promotion and HIV prevention services to 76,000 high risk MSM across London each year, as well as in-depth interviews with at least 4,000 MSM each year.
Methods 2888 online surveys identified existing literacy re-HIV self-testing and self-sampling in MSM (targeted via dating apps.) Recognising that literacy was limited, GMI provided community coaching on self-testing with MSM in high risk venues, to identify whether the intervention was more likely to engender comfort with new technologies (200 quantitative interviews).
Results HIV literate MSM do not understand the difference between self-testing and self-sampling.

The community coaching model ensures high levels of confidence and acceptability in self-testing technologies.
Discussion Community testing models can complement self-testing and self-sampling.

There will always be clients for whom online provision of new technologies will not work.

Scalability of the model within African groups (community based intervention).

P066 RISK REDUCTION' REFERRALS TO A SPECIALIST LONDON HIV AND SEXUAL HEALTH PSYCHOLOGY SERVICE

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Introduction Considering the low number of referrals of 'risk reduction' patients to the HIV and Sexual Health Psychology service in comparison to number of patients presenting with sexual risk taking at referring sexual health clinics, we implemented a 'sexual wellbeing' service development initiative in 2016.

We aimed to compare all the 'risk reduction' referrals in 2014 to 2016 in order to reflect on the impact of the service developments implemented in 2016.
Methods A retrospective case note review was conducted to identify referral rates to psychology over a 1-year period in 2014 and 2016. Age at referral, referral outcome and number of sessions were included.
Results The number of referral increased fivefold from 2014–2016. In 2014, 23 patients were referred. The mean age at referral was 32. 16 patients opted in to the service, 13 engaged in assessment/therapy. The mean number of sessions attended was 5. In 2016, 115 patients were referred. The mean age at referral was 36. 72 patients opted in and 48 patients engaged in assessment/therapy. The mean number of sessions was 3.

40 patients are still engaged with the service and will complete an intervention.
Discussion The service development initiative has resulted in a significant increase in the number of referrals to psychology. Further service initiatives are ongoing to address the continuing low number of patients opting in and engaging with psychological interventions.

P067 ALL BETTER NOW?: COMPLETING THE AUDIT CYCLE FOR PEPSE IN THE EDINBURGH GUM SERVICE

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10.1136/sextrans-2017-053232.112

Introduction Over 2014-2015 in the GUM clinic in Edinburgh we audited PEPSE (post exposure prophylaxis for sexual exposure) as per 2011 BHIVA guidelines. The initial audit results showed that we fell short of the BHIVA auditable standards, most noticeably for proportion of prescriptions within recommended criteria, completion of PEPSE course and STI testing. Based on the results of the audit and the updated 2015 BHIVA guidelines, changes were incorporated into a new local PEPSE pathway. Changes included more detailed patient discussion about whether PEPSE is recommended, providing full 28 day course at first visit if indicated and STI screening at initial visit. We have re-audited PEPSE prospectively August 2016 onwards to see if there was improvement in the standards after the new local guideline was implemented.
Method The following and demographics were documented on Excel Spreadsheet for patients who were prescribed PEPSE and compared with the results of the original audit.

Results For the initial audit in 2014–2015 n= 100, for the re-audit in 2016 at the time of submission n=80.

Abstract P067 Table 1 PEPSE Audit

Percentage of patients with (%)	2014–2015	2016	BHIVA guidance recommendation (2011/2015)
Baseline HIV test	81	90	100
Prescriptions that fit recommended indications	55	71	90
Prescriptions administered within 72 hours of exposure	83	100	90
Prescriptions within 24 hours of exposure	36	44	90
Completion of 4-week course of PEPSE	47	49 completed, 19 ongoing, 32 unknown or incomplete	75
STI screen	51	80	90

Discussion The results suggest marked improvement, though we still fall short of the auditable standards.

P068 PREP FOR IRELAND? AN NGO POLICY PAPER TO INFORM DISCUSSION ON LEGALISING THE AVAILABILITY OF PREP IN IRELAND

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Introduction PrEP is illegal in Ireland and the issue of the introduction of PrEP has not been adequately researched within an Irish context. This paper, due for completion in April 2017, examines the question, 'Should PrEP be introduced to Ireland?'

Methods A comprehensive literature review on PrEP has been completed, to be followed by key informant interviews with national and international stakeholders to ensure coherence with national policy, to capture multiple perspectives and priorities, highlight implementation and operational difficulties, and off-set unintended consequences.

Results The results of this paper will focus on PrEP within five key areas – Public Health Effectiveness, Adherence, Feasibility/Knowledge/Willingness to take PrEP, Risk/Risk Compensation, and Cost/Cost Effectiveness. The findings will contextualise PrEP within key populations of MSM, PWID, as well as Sex Workers and will inform Irish policy makers' decision making by providing input to debates on the pros and cons of introducing PrEP to Ireland.

Discussion It is argued that PrEP adds to the package of proven HIV prevention options already available and is recommended by UNAIDS for use in conjunction with other prevention methods. However PrEP is frequently not seen in value-neutral public health terms and is a contested intervention along economic, ethical, and rights-based axes. This paper examines PrEP in detail in order to inform discussion on its potential introduction within Ireland.

P069 POST EXPOSURE PROPHYLAXIS AFTER SEXUAL EXPOSURE: MANAGEMENT IN ED AND GUM

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10.1136/sextrans-2017-053232.114

Introduction Post-exposure prophylaxis following sexual exposure (PEPSE) is a method of preventing HIV infection. 2015 BASHH guidelines identify criteria for when PEPSE should and could be offered. Our aim was to review patients prescribed PEPSE either at our local Emergency Department (ED) or via GUM between 1st July – 31st Dec 2016 to establish if we are following the BASHH guidelines.

Methods This retrospective study identified patients that were prescribed PEPSE through the ED or GUM using electronic records and paper notes to audit criteria.

Results 176 PEP recipients were identified. Twenty-two of these were not associated with sexual exposure. Two were extending a current course of PEPSE due to new exposure; prescribed according to guidelines. 14 patients received PEP according to the ED register but no documentation was available. 7 patients received PEP in ED with documented exposure risk consistent with the BASHH guidelines but were lost to follow up. 131 PEP patients were seen in GUM. 6 patients presented to GUM after PEP was initiated at a different ED, all these were provided PEP according to guidelines. 35 presented after PEP was started in ED and the rest presented directly. 98% were prescribed PEP according to guidelines. There were 2 that were started on PEP in ED that was discontinued in GUM.

Discussion The majority of patients with available documentation were prescribed PEP according to guidelines. We intend to support our ED service in better documentation of patients presenting for, and prescribe, PEPSE.

P070 A RETROSPECTIVE AUDIT OF THE PROVISION OF PEPSE IN A COMMUNITY SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.115

Introduction When setting up a specialist GUM clinic within a community sexual and reproductive health service we started offering Post Exposure Prophylaxis (PEPSE) to eligible patients. The patient pathway was to start PEPSE in our service, then attend the HIV clinic in the hospital for all related follow-up appointments.

Aims To audit our practice against the 2011 BHIVA guidelines for the use of PEPSE.

Methods Our electronic record was interrogated for consultations coded as PEPSE between January 2013 and July 2015.

78 records were found, of whom 5 did not receive PEPSE. Thus 72 records were audited.

Results

Abstract P070 Table 1 PEPSE Audit

	Number (%)	Audit Standard	Setting
HIV test within 72 hours	72 (100)	100%	Community
Prescription fits indication	72 (100)	90%	Community
PEPSE within 72 hours	72 (100)	90%	Community
Completing 4 weeks PEPSE	21 (29.2)	75%	Hospital
Full STI screen	58 (80.6)	90%	Hospital
HIV test 12-weeks post PEPSE	18 (25%)	60%	Hospital

The BHIVA standards were met in all categories that were implemented in the community GUM clinic, but were not met in any of the categories that were implemented in the hospital setting.

Discussion While it is encouraging that PEPSE was initiated successfully in our clinic setting, the follow-up data was disappointing. Following the results of this audit all patients who start on PEPSE in our community clinic are now followed up in the community.

P071 PRE PREP PREP

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10.1136/sextrans-2017-053232.116

Introduction Sexual health of MSM has worsened over the last decade and with NHS PREP provision on the horizon we needed to assess the current sexual health of MSM attending our small integrated sexual health clinic to ascertain who may be eligible for PREP.

Methods Retrospective case notes review of all MSM attending as a new or rebook attendance in 2015.

Results 140 attendances of MSM in 2015 were analysed. 136/140 (97%) had a HIV test. 36/140 (26%) were diagnosed with an STI of which 10 were rectal STIs. 62/140 (44%) had a previous STI. Documented recent unprotected anal sex occurred in 80/140 (57%), 3 patients were in a sero-discordant relationship- all had partners with an undetectable viral load. Recreational drugs were used by 9/140 (6%) of which 4 patients were engaged in chem-sex.

80/140 (57%) patients would fulfil the baseline criteria for PREP.

Discussion MSM in our clinic have a high rate of STIs and more than half have had recent unprotected anal sex. There is a low rate of recreational drug use. Over half would be eligible for PREP if they continued in engage in unprotected sex. Repeated attendances through 2015 will be analysed to assess behaviour change.

P072 DO WE MEET THE CRITERIA? CONSIDERATION FOR PREP PROVISION LOCALLY

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10.1136/sextrans-2017-053232.117

Introduction With various studies demonstrating Pre-Exposure Prophylaxis (PrEP) as highly effective in reducing HIV transmission, Health Departments are under pressure to provide the treatment.

Methods Questionnaire feedback from 60 men who have sex with men (MSM) attending sexual health clinic, questions were based around the eligibility criteria for the PROUD study and some additional information we felt may be useful.

Results 58 MSM & 2 Trans women: 35 (58%) reported unprotected anal intercourse (UPAI) in the past 3 months, average number of partners 7. 6/35 had treatment for an infection in the past 6 months, all Gonorrhoea. 25 MSM (42%) reported no UPAI in past 3 months, average number of partners 2. 2 treated for infections, 1 GC and 1 had Syphilis and Chlamydia. Overall 16 (27%) reported drug use, no IVDU. 43 (72%) used social media to meet partners, 16 (27%) used male only saunas. 56 (93%) would use PrEP if available. 24/60 was asked if using PrEP may encourage them to have UPAI, 5 (20%) responded yes. 6 (10%) had used Post Exposure Prophylaxis following Sexual Exposure (PEPSE). In the last 2 years we provided 216 MSM with PEPSE, 29 (14%) used it more than once, 5 (2%) are now HIV positive.

Discussion There appears to be high risk behaviour within our MSM cohort. PrEP has a role to play in prevention of HIV transmission, if funding became available for PrEP the service may need to find ways to target the higher risk individuals. 58% met the recommended criteria by BASHH/BHIVA.

HIV Testing, New Diagnoses and Management

P073 DO FINANCIAL INCENTIVES (FI) AND MOTIVATIONAL INTERVIEWING (MI) PROMOTE ADHERENCE IN VERTICALLY INFECTED HIV POSITIVE ADOLESCENTS?

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10.1136/sextrans-2017-053232.118

Introduction Funding was received for 10 patients to participate in a FI & MI scheme aiming to achieve viral load (VL) reduction.

Methods Eligibility criteria: 16-25 years, vertically acquired HIV-1 infection, CD4 <350 cells/ul, agrees to ART with treatable virus, poor adherence since diagnosis & failure to achieve VL <40 copies/ml. FIs received for VL reductions $\geq$ 1 log weeks 2 & 4 and VL <40 week 8, 3/12, 6/12, 9/12 and 1

year. £20 given for VL reduction ≥ 1 log and £50 for VL <40. Adherence support with motivational interviewing (MI) was provided at each visit.

Results 8 patients enrolled 1/8/12–1/12/15. 5 females, median age 24 years (range 20–26). Mean baseline VL 35750, this reduced to 1390 (mean VL reduction 21842 copies/ml). 5/8 patients achieved VL <40. N=1 had never achieved VL <40, yet during the scheme achieved VL <40 for 8/12. 3 patients were unable to achieve VL <40. Their lowest VL was 71, 883 and 90, representing a 1–2 log VL drop from baseline after 52/12, 4/12 and 1/12, respectively. 1 patient passed away following a Steven-Johnson reaction, never achieving VL <40. Financial incentives given totalled £640.

Discussion Despite widely available treatment options for HIV, preventable deaths still occur each year due to a lack of adherence. Within this cohort, 5 patients were able to achieve periods of VL <40 after years of detectability. These results highlight that FI in conjunction with MI, may have a role in improving adherence for the adolescent HIV infected population.

P074 SIGNIFICANT EFFICACY AND LONG TERM SAFETY DIFFERENCE WITH TAF-BASED STR IN NAÏVE ADULTS

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10.1136/sextrans-2017-053232.119

Introduction At Week(W) 48, elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide (E/C/F/TAF) was statistically noninferior to E/C/F/tenofovir disoproxil fumarate(TDF) for the proportion of subjects with HIV-1 RNA <50 copies (c)/mL and had significant improvements in renal and bone safety endpoints. We report W144 data.

Methods ARV-naïve participants randomised 1:1 to receive E/C/F/TAF or E/C/F/TDF. W144 viral suppression (HIV-1-RNA <50 and <20 c/mL) by FDA snapshot analysis, pre-defined bone and renal safety, and tolerability endpoints are reported.

Results 1,733 HIV-infected adults were randomised and treated: 15% women, 43% non-white, 23% viral load (VL) >100,000 c/mL. Median baseline characteristics: age 34 years, CD4 count 405 cells/μL, and VL 4.58 $\log_{10}$ c/mL. At W144, E/C/F/TAF met pre-specified criteria for both non-inferiority and superiority to E/C/F/TDF by FDA snapshot algorithm (HIV-1-RNA <50 and <20 c/mL) (Table 1). Mean decrease in BMD was significantly less in the E/C/F/group for lumbar spine and hip (Table1). Multiple measures of renal safety were significantly better for participants on E/C/F/TAF (Table). No cases of renal tubulopathy in the E/C/F/TAF group vs 2 on E/C/F/TDF. No participants on E/C/F/TAF had renal-related discontinuations vs 12 on E/C/F/TDF (p<0.001). Participants on E/C/F/TAF had greater increases in lipids.

Discussion E/C/F/TAF was significantly superior than E/C/F/TDF, driven by fewer participants on E/C/F/TAF with no W144 data. E/C/F/TAF continued to have a statistically superior bone and renal safety profile compared with E/C/F/TDF, demonstrating significant safety advantages over E/C/F/TDF through 3 years of treatment. Individuals on E/C/F/TAF had greater plasma lipid changes, but proportions starting lipid-lowering therapy were comparable.

P075 EFFICACY AND SAFETY OF SWITCHING TO EVG/COBI/FTC/TAF IN VIROLOGICALLY SUPPRESSED WOMEN

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10.1136/sextrans-2017-053232.120

Introduction Elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate(E/C/F/TDF) demonstrated superior efficacy when compared with atazanavir boosted by ritonavir(ATV/r+F/TDF) in 575 treatment naïve women at Week(W) 48. We now report the safety and efficacy of subsequent switching to E/C/F/tenofovir alafenamide(TAF) versus remaining on ATV/r+F/TDF.

Methods After completing the initial randomised, blinded 48-week trial,women on ATV/r+F/TDF were randomised 3:1 to receive open label E/C/F/TAF versus remaining on their current regimen. Viral suppression by FDA snapshot analysis, predefined bone and renal safety and tolerability endpoints 48 weeks after switch are reported. Women who become pregnant while on study are given the option to continue study drug.

Results 212 HIV-infected, virologically suppressed women were randomised(E/C/F/TAF n=159, ATV/r+F/TDF n=53). Virologic suppression(<50c/mL) was maintained in 94.3% on E/C/F/TAF vs 86.8% on ATV/r+F/TDF with virologic failure in 1.9%, 3.8%, respectively. More women on E/C/F/TAF achieved <20c/mL at W48 compared with ATV/r+F/TDF (84.9% versus 71.7%p=0.041). No treatment emergent resistance was detected in either group. Mean% increase in BMD was higher in the TAF group for both lumbar spine and total hip. Multiple markers of renal safety were improved for participants randomised to TAF. No cases of proximal renal tubulopathy were reported. Nineteen women became pregnant during the switch study 13 E/C/F/TAF, 6 ATV/r+F/TDF,3 normal infants have been delivered in each group to date.

Discussion These data demonstrate that women who switch to an integrase inhibitor+TAF-based regimen maintain high levels of virologic suppression with improvement in BMD and renal function biomarkers compared with those remaining on their ATV/r+TDF-based regimen.

P076 FIVE YEARS OF FEEDBACK FOR THE NEWLY DIAGNOSED COURSE – AN EVALUATION OF A PEER-LED INTERVENTION FOR PEOPLE DIAGNOSED WITH HIV

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10.1136/sextrans-2017-053232.121

Introduction New diagnosis of HIV can be psychologically challenging, and presents an important opportunity to improve health literacy and engagement in care. Peer-led interventions are an effective means of providing support to people living with HIV (PLWH). We present an evaluation of a newly-diagnosed course (NDC) in London.

Method The NDC, established in its current form in 2011, is accessible to 'those recently diagnosed or struggling with diagnosis'. Providing a structured, peer-led, group-based, participatory programme delivered by experienced facilitators. NDC comprises 6 sessions (21 contact hours). All participants were invited to complete pre-and post-course questionnaires (using a 4-or 5-point scale), most did at the first and last sessions. This analysis presents data from 2011-2016. Data were analysed in STATA using Wilcoxon signed rank test.

Results Across 30 NDCs, 314 participants completed both questionnaires (response rate 87%). The majority were men who have sex with men (91.3%), 72% of whom were of white ethnicity. Approximately 15% were female, the majority Black-African ethnicity (56%) and heterosexual (88%). Heterosexual men and transgender individuals represented 6.5% and 0.3% respectively. The table summarises participant's responses for selected questions (P Values <0.001 for all comparisons):

Pre- and Post-Course Questions:	•Pre-course n/N (%)	•Post-course n/N (%)
*Current emotional state	144/136 (43)	287/339 (85)
*Confidence in dealing with HIV status	130/335 (39)	307/339 (91)
*Confidence around sex and relationships	46/336 (14)	172/279 (62)
*Confidence in the future	130/338 (39)	290/332 (90)
How confident do you feel about disclosing your HIV status?	26/338 (8)	136/340 (40)
How satisfied are you with your ability to get more information about HIV medications?	97/336 (29)	130/314 (41)
How much knowledge do you have about how HIV is transmitted?	183/337 (54)	324/340 (95)
How much do you know about how to access Post Exposure Prophylaxis (PEP)?	169/337 (28)	274/340 (81)
How much knowledge do you have about CD4 count and HIV viral load?	82/337 (24)	300/340 (88)
Personal satisfaction with NDC overall n/N (%) rating 'mostly' or 'fully' useful		**324/328 (99)**

*Questions headed: 'Thinking about your HIV how would you rate the following' Respondents rating highest using 4- or 5-point scale

Discussion This innovated peer-led NDC engaged over 300 PLWH since 2011, resulting in short-term self-reported improvements. 6-and 12-month questionnaires would assess durability of changes, and we're exploring the association with attendance at NDC and clinical outcomes (e.g. viral suppression and retention in care). In conclusion, the NDC is a sustainable and acceptable model, providing holistic support and promoting self-management in PLWH.

P077 WHAT ARE THE PERSPECTIVES OF KEY INFORMANTS ON THE IMPLEMENTATION HIV SELF-TESTING (HIVST) IN ENGLAND? A QUALITATIVE STUDY OF BARRIERS, FACILITATORS AND ANTICIPATED IMPACTS

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Introduction HIVST is a new approach for individuals to test themselves for HIV in a location and at a time of their choosing using a rapid diagnostic test. This approach has the potential to increase testing uptake and frequency. Questions remain about where and how to situate HIVST in a landscape of diverse HIV testing provision. This study aims to understand the perspectives of key informants on the implementation of HIVST.

Methods In order to inform development an intervention for use in a trial recruiting men who have sex with men (MSM) and transgender people, we conducted in-depth interviews with 17 key informants (KIs) including clinical staff in HIV and STI services, voluntary sector service providers and HIV testing commissioners. Interviews were transcribed verbatim and analysed using a thematic framework analysis.

Results KIs valued HIVST for providing patients with additional choice. Careful attention to intervention design was important as local context and client group shaped anticipated patient response to HIVST. Interventions should deliver HIVST through integrated approaches that provide direct pathways into additional testing services and HIV care. Anticipated impacts were a loss of support from face-to-face testing services, the possibility of increased risk of self-harm, reduced STI detection, but conversely HIVST also increased potential for empowerment.

Discussion HIVST interventions should be responsive to context, taking into account both local and national needs. Concerns centred on potential negative impacts indicating that innovative service delivery designs which address these may be key to KI buy-in for HIVST implementation and patient outcomes.

P078 USER PARTICIPATION IN THE DEVELOPMENT OF HIV SELF-TESTING SERVICES: RESULTS OF CO-DESIGN WORKSHOPS

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Introduction Novel ways to encourage HIV testing are urgently needed. In Brighton, the use of a digital vending machine to distribute free self-test kits to men who have sex with men (MSM) using saunas is being piloted along with a campaign to increase awareness of self-testing.

Methods Volunteers attended design workshops and designers attended an LGBT community meeting. Participants completed a questionnaire and discussed visual concepts for the campaign. Workshops utilised tools such as personas (creating 'characters' to explore theoretical individuals' thoughts and behaviours), construction of user journeys, and mock-ups of vending machine design and interaction.

Results There were 11 respondents; 8 aged <25, two 25–34 and one 45–64 years. Eight had previously tested for HIV. Two had self-tested. Themes relating to concerns with self-testing were: perceived reliability or 'faith in the results'; tests being 'done properly'; familiarity with self-testing; fear of needles or blood; STI screening; support if test positive. Factors encouraging HIV self-testing were: awareness; accessibility; confidence in ease of use. Key themes relating to visual campaign options were: sense of community and support; clinical versus community settings; giving clear information. Participant discussions using personas included targeting appropriate

populations for self-testing and framing the campaign within the 'gay scene'.

Discussion

Few participants had previously self-tested Knowledge and generating a 'sense of a testing community' were the most important factors for promoting self-testing. Collaboration with designers and communities ensures a user-centred approach to HIV self-testing.

P079 ARE PATIENTS WITH UNEXPLAINED BLOOD DYSCRASIAS BEING TESTED FOR HIV?

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10.1136/sextrans-2017-053232.124

Introduction The purpose of our audit was to determine whether our hospital is following the BHIVA National Guidelines (2008) and testing for HIV in patients presenting with unexplained blood dyscrasias.

Methods Our initial sample consisted of all inpatients coded as having lymphopenia, thrombocytopenia or neutropenia between 1/1/16 and 1/11/16. We excluded patients with a known cause of cytopenia and those with mild cytopenias (platelets >80, neutrophils >1, lymphocytes>1). In our final sample of 82 patients, we used the electronic ordering system to collect patient and admission information and to determine whether a HIV test was ordered.

Results 37% of patients with unexplained blood dyscrasias were tested for HIV. 60% of patients with neutropenia were tested compared with 42% with thrombocytopenia, 25% with lymphopenia and 20% with mixed cytopenias. Patients with lower blood counts were more likely to be tested for HIV. Patients were more likely to be tested for HIV if they were admitted under the haematology team (55%) compared with those admitted under general medical (31%) or surgical teams (27%). HIV testing declined with increasing age of patients with 67% of those aged under 30 being tested compared with 60%, 56%, 22% and 0% of patients between 31–50, 51–70, 71–90 and over 90 respectively.

Discussion We found that the majority of patients with unexplained blood dyscrasias were not tested for HIV. Our study highlighted several factors that influence whether testing is performed. These include the nature and severity of cytopenia, patient age and the admitting medical team.

P080 DRAMATIC REDUCTIONS IN NEW HIV DIAGNOSES FOR MSM IN ENGLAND ARE NOT UNIFORM FOR ALL ETHNICITIES IN A LARGE LONDON CLINIC

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10.1136/sextrans-2017-053232.125

Introduction Along with many other GUM clinics, we are seeing a reduction in new HIV diagnoses in MSM. Our clinic is based in East London and sees MSM of all ethnicities. Preliminary data analysis suggests that this reduction may not apply to the BME MSM population.

Methods We analysed HIV testing rates from our large London GUM clinics. HIV tests, along with demographic data, sexual risk and ethnicity are collected routinely. We then compared positivity rates between ethnicities in 2015 and 2016.

Results Over 2015 and 2016 there were 48,512 HIV tests performed, of which 12,248 (25%) were on MSM. There was a slight decrease in the number of HIV tests in MSM from 6,688 in 2015 to 5,560 in 2016. We saw a significant reduction in the numbers of new HIV diagnoses in MSM from 43 in 2015 to 25 in 2016. This reduction in new HIV diagnoses was seen in those of white ethnicity (from 30 in 2015 to 15 in 2016) and black ethnicity (from 5 to 3). However, this reduction was not seen in Asian MSM (2 diagnoses each year).

Discussion New diagnoses of HIV are declining in MSM, likely due to treatment as prevention and PrEP. However, it appears that these significant drops are not uniform. Asian MSM may be less likely to engaged with traditional GUM services. Targeted work is needed to engage this group and help reduce HIV diagnoses further.

P081 THE COST OF COST-SAVING HIV DRUG SWITCHES IN A SMALL DGH HIV UNIT

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10.1136/sextrans-2017-053232.126

Introduction In July 2016 NHSE circulated a letter regarding Commissioning for Value and antiretroviral drug switches. The letter noted that 'These switches have been identified as not needing to recall patients to clinic or to introduce additional monitoring arrangements unless clinically indicated or the patient requires further support'. However the e-GFR decreases after starting cobicistat and checking at 4/52 is recommended.

Methods Patients suitable for antiretroviral drug switches were identified by pharmacy, a total of 50 patients (53% of our cohort). A review of the outcomes up to Jan 2017 was undertaken.

Results Eleven patients switched successfully from Kivexa to generic abavavir/lamivudine. Fifteen switched from Atripla to Truvada/efavirenz. Of these, four switched back due to side effects. In one case 4 months of drugs, costing £1384, were wasted. Two patients did not tolerate Rezolsta (AKI & diarrhoea). There were ten extra visits for safety bloods. The first prescription for the switches for all regimens was for two months to minimise waste. Additional staff time was required to generate the prescriptions, and the additional deliveries cost £1215 to date.

Discussion Switches from Atripla to Truvada/efavirenz and from PI/r to PI/cobicistat involved additional costs in terms of staff time, delivery charges and drug wastage. In December 2016, we decided to halt the switches to PI/cobicistat, as it was felt that the cost savings were insufficient to compensate for the additional workload, and also it might be a challenge to switch patients back to two drugs when generic darunavir and atazanavir become available.

P082 IMPLEMENTING AND SUSTAINING HIV TESTING IN ACUTE MEDICINE – RESULTS FROM THE FIRST 2 YEARS

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10.1136/sextrans-2017-053232.127

Introduction Leeds is an area of high HIV prevalence of 2.3/1000 and in accordance with National UK guidelines for HIV testing we introduced routine opt out HIV testing to the acute medicine unit at St. James's University hospital in January 2015. Opt out testing is offered to patients between 16 and 65 years of age admitted to any of the acute medical areas.
Methods Ensuring high testing rates in this busy environment with rapidly changing medical staff is challenging and we have used a number of interventions to help sustain a high testing rate. These include providing weekly feedback and training to the acute medicine doctors and nurse practitioners, an electronic prompt on the Ordercoms pathology system and for patients who have blood tests in the emergency department, the facility to have HIV testing performed on samples sent to biochemistry. We employ a 0.5 WTE nurse to support this project.
Results Between January 2015 and February 2017 there have been 11,715 eligible patients admitted of which 7263 (61%) patients underwent HIV testing. HIV testing was highly acceptable to patients with almost no patients refusing the offer of an HIV test. 16 patients (0.22%) had a positive HIV test and 2 partners were subsequently tested positive. 10 of the 16 patients had a very late diagnosis with a CD4 count <200 cells/mm^3 and we identified many missed opportunities for earlier diagnosis. 2 patients had primary HIV infection and would almost certainly not have been tested otherwise.

P083 HOW DO HIV TESTING INITIATIVES IMPACT ON HIV TESTING RATES AND DIAGNOSIS IN PRIMARY CARE?

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10.1136/sextrans-2017-053232.128

Introduction Undiagnosed HIV leads to late presentation, increased morbidity, and contributes to onward transmission. It is estimated that in our area approximately 17% of those living with HIV are undiagnosed. Little is known about the impact of National HIV Testing Week (NHTW) initiatives in general practice (GP). In 2016 we implemented a 'pop-up' message alerting GPs that it was NHTW, with a 'one-click' pathway to adding an HIV-test to bloods requested for other reasons.
Methods Number of HIV tests carried out in GP and new HIV diagnoses made were collected between 20th August 2016 and 20th February 2017 and separated into the time period spanning 3 months pre-NHTW, NHTW itself and 3 months post-NHTW.
Results 464 HIV tests were performed in 37 GP practices in the pre-NHTW period (approx. 36/week), 96 test during NHTW and 534 tests in 3 month post-NHTW (approx. 41/week). 1 HIV-diagnosis was made in GP during the pre-NHTW period (c.f. 20 across all services), no new diagnoses in NHTW and 1 case (7 across all services) in the 3 month post-NHTW period.
Discussion Testing initiatives result in greater awareness across the city and an increase in HIV testing, which was sustained, although no increase in new HIV diagnoses. The decrease in HIV diagnoses in this study reflects the national trend of a reduction in HIV diagnoses despite increased testing; this is attributed partly to the efficacy and increased use of Pre-exposure prophylaxis (PrEP).

P084 ARE WE CONSIDERING HIV ENOUGH? AN AUDIT INVESTIGATING ROUTINE USE OF HIV SCREENING FOR PATIENTS AGED 18–50 PRESENTING WITH COMMUNITY ACQUIRED PNEUMONIA TO A PROVINCIAL HOSPITAL

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10.1136/sextrans-2017-053232.129

Introduction It is known that a significant proportion of people within the United Kingdom are unaware of their HIV infection and late diagnosis is associated with HIV related Morbidity and Mortality. The British HIV Association recommend routine HIV screening for patients with an HIV indicator illness. This includes Bacterial Pneumonia, a condition commonly encountered in hospital departments throughout the United Kingdom.
Methods We designed an audit to evaluate the use of routine HIV screening for patients aged 18-50 presenting to the Royal Devon and Exeter Hospital with Community Acquired Pneumonia. Using a coding search of all discharges between May 2015 and September 2015, 38 patients were identified. Inclusion criteria required each patient to have either a positive microbiological sample or consolidation present on a chest radiograph. Of the 38 patients identified, 7 were excluded who did not satisfy the minimum inclusion criteria.
Results Of the patients audited, 21 patients (67.7%) did not receive routine screening during their inpatient stay. One patient who was not tested had received testing immediately prior to their acute presentation. Two patients who were not tested had a significant history of intravenous drug use, an independent indicator for routine HIV screening. Of the 10 patients (32.3%) that were successfully screened for HIV, no samples tested positive.
Discussion Routine screening for HIV in all patients with bacterial pneumonia could aid early identification of HIV infection, reducing overall morbidity and mortality. This audit highlights the continuing need for raised awareness of routine HIV screening for patients with HIV indicator conditions, particularly, in areas of low prevalence of HIV infection.

P085 AN AUDIT OF NICE GUIDANCE PH33; INCREASING THE UPTAKE OF HIV TESTING IN BLACK AFRICANS

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10.1136/sextrans-2017-053232.130

Introduction In 2015, Wolverhampton had the highest rates (15.8 per 100,000) of newly diagnosed HIV in West Midlands and In the West Midlands incidence rates in the black African ethnic group remain much higher than those for other ethnic groups, with a relative risk of 34 compared with the white group in 2015. This clearly shows the importance of the NICE Guidelines PH33 which was published in 2011 which aimed to increase the uptake of HIV testing in Black Africans and we wanted to audit this guidance.
Methods A list of patients classified as being of Black African ethnicity who were admitted to the Acute Medical Unit at Royal Wolverhampton NHS Trust between April 2015 and January 2016 was obtained. Their medical notes and blood test results were retrospectively analysed for evidence of testing or any discussion of HIV tests.

Results 50 case notes were retrospectively reviewed. An HIV test was not offered in 87% of admissions despite 15% of them presenting with signs of clinical indicator diseases. Only 6 patients were offered a test during their admission, of which 5 of them accepted. 1 of these tests was HIV positive and the patient was referred for further care to the HIV service within the trust.
Discussion There remains a barrier to HIV testing in high risk populations in non-GUM settings despite NICE guidance published several years ago. Recommendations include the need to identify existing barriers by surveying doctors and providing education on how to overcome them, and the addition of prompts on clerking proformas may encourage universal testing.

P086 ROUTINE HIV TESTING IN PRIMARY CARE: DOES TARGETED TRAINING WORK?

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10.1136/sextrans-2017-053232.131

Introduction Late diagnosis of HIV infection remains a major barrier to tackling HIV. UK HIV testing guidelines recommend universal testing of all new registrants attending general practice (GP) where local HIV prevalence exceeds 2/1000. HIV prevalence in our city was 1.1/1000 with pockets of high prevalence centred on 6 zones of deprivation. We targeted GP practices in these areas to undertake routine HIV testing after in-house training and ascertained healthcare professionals' (HCP's) views in relation to HIV testing in primary care before and after training.
Methods 13 GP practices in 6 high prevalence areas were approached alongside public health to undertake routine HIV testing, with remuneration and training, delivered as a lecture and discussion. Pre and post -training questionnaires were done assessing attitudes and knowledge around testing.
Results 7 GP practices accepted. Pre and post training responses (49 in total) reported increased confidence around when to offer testing (40%), discussing testing (20%), and awareness of national guidelines (63%). Increased numbers offered tests to MSM (39%), patients from high risk countries (29%), and for indicator conditions (14%). The number of HCP's offering testing in the preceding month increased by 20%. Reasons for declining testing remained unchanged (83% self-perceived low risk, 50% stigma concerns) as were practical barriers which were predominantly time restraints.
Discussion Targeted training improved key areas of understanding and built confidence around routine HIV testing among local GP practices. Perceived barriers to testing and reasons that patients declined testing remained unaltered after training.

P087 INFORMATION GAPS FOR HIV POSITIVE PATIENTS DETAINED IN IMMIGRATION REFERRAL CENTRES (IRCS)

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10.1136/sextrans-2017-053232.132

Introduction HIV is over-represented in this high risk, vulnerable population. Detainees often have complex health needs which present challenges to chronic disease management. Transfer of information between care providers is crucial to maintain appropriate management of these vulnerable patients. We aimed to look at the information shared between health care providers for detainees referred to our HIV service.
Methods We reviewed all referrals from the local IRC to our HIV service between September 2014 and January 2017, looking at information provided on the IRC referral letter and supplied by their previous care provider.
Results Out of 24 referrals, the notes were available for 17. CD4 count, HIV RNA and HAART regimen were missing from 9, 10 and 1 of the IRC referrals respectively. Information was missing about adherence in 9, treatment interruption in 10, and co-medications in 11 referrals. 9 reported requesting information from previous HIV provider; this was not received in 4 cases. In the 11 cases where information was received from the previous HIV care provider, information was not included on co-medications in 8, hepatitis B status in 6, hepatitis C status in 8, resistance testing in 5, and HLAB*5701 status in 6 summaries.
Discussion We highlight the need for standardised information transfer between care providers in these patients. In Dec 2016 we devised a form to send to previous HIV service providers to collect the required information for safe prescribing prior to their GUM appointment. We plan to review whether this improves the quality of information received.

P088 ANTIRETROVIRAL TREATMENT ALGORITHM COMPLIANCE: A REGIONAL AUDIT AND SURVEY

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10.1136/sextrans-2017-053232.133

Introduction In 2015 BHIVA introduced new treatment guidelines and NHS England produced an algorithm for antiretroviral (ARV) treatment initiation, with a requirement to have regional and local multidisciplinary team (MDT) arrangements to aid decision making.
Methods 6 services within our regional clinical HIV network carried out a retrospective audit of 20 (or total if fewer) cases started on ARVs in 2015, and completed a survey of each centres MDT arrangements. Data from each centre was collated and analysed regionally.
Results Local MDT arrangements varied widely in number and composition of professionals. All centres reported a change in practice and discussed non-first line regimens. 98 case notes were included. 43/98 started due to CD4 <350, 17 for primary HIV infection or symptoms, 16 for Treatment as Prevention, and 14 patient choice. An increase in abacavir/lamivudine based regimens was seen after algorithm instigation in April 2015. Mental illness, HIV viral load >100K, patient choice and shift work were the commonest reasons for choosing non-first-line regimen. 90% overall compliant with the NHS England treatment algorithm.
Discussion MDT arrangements and interpretation of the algorithm varied in our network. Prescribing practices have changed throughout the region since algorithm introduction. Further work is needed as a network to ensure standardised ARV prescribing for both cost and equity of patient care.

P089 PJP DIAGNOSIS IN THE HAART & PCR ERA

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10.1136/sextrans-2017-053232.134

Introduction In the HAART era, Pneumocystis jirovecii Pneumonia (PJP) continues to be a major opportunistic infection. PJ PCR is increasingly available to support the diagnosis of PJP. A 'low level' PCR result may represent PJ colonisation or a poor-quality specimen. Upper airway samples such as throat swabs (T/S) are also more likely to yield a negative or low level positive.

Method Retrospective review of all HIV-infected adults with respiratory tract PCR-confirmed PJP and pneumonia over an 18 month period. Demographics, clinical features, management, clinical outcome and laboratory parameters were recorded.

Results 4/12 patients had negative T/S PJP PCR test before the diagnosis was confirmed. The mean cycle threshold (CT) value for throat swabs was *34.04*. The mean CT value for sputum was *32.05*.

Discussion PJP PCR is a useful investigation. PCR will detect more cases than traditional tests (direct organism visualisation). This leads to earlier PJP treatment and earlier screening for HIV. While there is a trend towards lower CT value results in sputum when compared with throat swabs, any positive PJP result should trigger the offer of a HIV test. Patients with a negative URT PCR and clinical suspicion of PJP should receive empiric treatment and where appropriate proceed to BAL, as per national guidance.

P090 FORMALISED LOOK-BACK IN NEWLY DIAGNOSED HIV TO IDENTIFY MISSED OPPORTUNITIES IN OTHER CLINICAL SETTINGS: FIRST GET OUR OWN HOUSE IN ORDER!

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10.1136/sextrans-2017-053232.135

Introduction HIV late diagnosis is one of three key indicators on sexual health in the Public Health Outcomes Framework. The British HIV Association (BHIVA) Standards of Care for People Living with HIV advocates the use of 'look backs' in the case of late and very late diagnosis of previous engagement with health care services to identify missed opportunities and areas for shared learning and development.

Methods Further to the look-back exercise undertaken on late and very late diagnoses presenting 2012–2016, we extended the use of the standardised look-back tool to ALL new diagnoses from late 2016 onwards.

Results In addition to anticipated missed opportunities being identified in the late and very late presentations, we identified 2 missed opportunities in much earlier presentations from within our own service! They related to failure to repeat the HIV test at test of cure (TOC) for gonorrhoea and subsequent Hepatitis vaccination appointments. In both cases the initial negative HIV test had been within the potential window period.

Discussion As a result of the look-back exercise we have learnt a valuable lesson about the fallibility of our own service and shared the learning within our multi-disciplinary team. We

Abstract P089 Table 1 Patients with PJP (in order of immunosuppression)

Age at HIV diagnosis, gender, behavioural risk	Category	CD4+ count at PJP diagnosis, PJP severity	PJP test 1 (Ct value, site)	PJP test 2 (Ct value, site)	Clinical outcome
	Known HIV				
39/M/IDU	On ART for 4 weeks, not on PJP prophylaxis	200, mild	37.0, TS	n/a	Survived
38/M/MSM	Defaulted from care, not on ART	10, severe	Neg., TS	32.5, TS	ICU care, survived
	Missed opportunity to diagnose HIV				
53/M/MSM	Unexplained diarrhoea and weight loss	70, severe	30.0, SPU	26.2, SPU	ICU care, deceased
43/F/heterosexual	Unexplained lymphadenopathy and weight loss	50, severe	26.4, SPU	Neg., TS	Readmitted with hypoxia, survived
32/F/heterosexual	Campylobacter gastroenteritis	50, severe	36.4, TS	25.3, SPU	ICU care, survived
56/M/unknown	–	30, severe	Neg., TS	31.5, SPU	ICU care, deceased
39/M/heterosexual	Unexplained weight loss	20, mild	Neg., TS	25.0, SPU	Survived
62/M/MSM	Unexplained weight loss	20, mild	26.0, BAL	n/a	Survived
55/M/MSM	Bacterial pneumonia	20, mild	33.0, SPU	n/a	Survived
52/M/heterosexual	–	10, severe	30.3, SPU	34.9, SPU	ICU care, survived
57/M/MSM	Unexplained weight loss	10, severe	39.0, SPU	n/a	ICU care, survived
52/M/heterosexual	Chronic diarrhoea, bacterial pneumonia	0, severe	Neg., SPU	28.0, SPU	ICU care, hypoxia requiring long-term home-O_2

Note- **BAL** broncho-alveolar lavage; **F**: female; **M**: male; **ICU**: intensive care unit; **IDU**: intravenous drug user; MSM men who have sex with men; **n/a**: not available; **Neg.**: PCR not detected; **SPU**: sputum, **TS**: throat swab
PJP severity ('mild': mild-moderate, or 'severe': moderate-severe, by BHIVA criteria)

have encouraged all to remember to re-visit the sexual history and timing of sex in relation to testing at 'quickie' follow up visits for vaccination or TOC and repeated education about window periods.

We shall continue to utilise the look-back tool in all new HIV presentations and encourage colleagues to do likewise to maximise on identifying learning opportunities.

P091 NEW HIV DIAGNOSES AMONG WOMEN IN A LARGE TEACHING HOSPITAL

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Introduction In 2014 there were an estimated 103,700 people living with HIV (PLHIV) in the UK, approximately one third were women. In 2015 there were 965 PLHIV in our cohort, 215 were women. There are few data available on HAART in women, other than in pregnancy. Socio-economic and cultural factors may also affect their ability to access care. Other factors affecting women include contraception, conception and pregnancy.

Methods A retrospective chart analysis was carried out on all new diagnoses among women over a 3-year period, from April 2013 to April 2016. Patients who had previously been diagnosed elsewhere were excluded.

Results There were 286 new diagnoses of HIV in this period; 44 (15%) were women. 41% of patients were local, 39% were of African origin. 57% of patients were diagnosed late, having CD4 <350 at diagnosis. 8 patients were pregnant; there were no vertical transmissions. Existing children were tested were possible; no positive diagnoses were made. A number of male partners were diagnosed through partner notification. The majority of patients commenced HAART and reported good adherence.

Discussion Women make up a significant proportion of PLHIV, though rates in our region are lower than in the rest of the UK. The majority of positive women in the UK are of black African origin, though in our cohort a higher proportion were born locally. Many of these women are diagnosed late, and with no identifiable traditional risk factors. There are a number of important gender-specific factors associated with HIV-positive women and these should not be underappreciated.

P092 NATIONAL HIV TESTING WEEK 2016: INCREASING HIV AWARENESS AND TESTING OPPORTUNITIES THROUGH A COORDINATED NATIONAL EVENT

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10.1136/sextrans-2017-053232.137

Introduction National HIV Testing Week (NHTW) is an annual event co-ordinated by HIV Prevention England (HPE) which aims to increase HIV testing in England, as well as to increase awareness and acceptability of HIV testing among key populations. It takes place each November in the lead-up to World Aids Day.

Methods Digital and print promotion of: the event and postal testing services, as well as digital interactive information tools which seek to reduce barriers to testing. Provision of printed resources, including customizable and community-language posters to promote local testing events. A post-event evaluation to assess the effect of the campaign was also completed by the organisations involved.

Results For NHTW 2016, 100 organisation representatives responded to the post-event evaluation. 65% agreed that NHTW increased their capacity to impact their community/clients. The biggest impact was through increasing awareness of the importance of HIV testing in the local community (86%), followed by delivering more HIV tests (57%). Of those organisations who provide HIV testing, 33% provided at least twice as many tests in testing week compared with a regular week.

Nearly 320 organisations ordered 400,931 NHTW resources. 211 testing events were registered on the website and 5,740 HIV home-sampling kits were ordered by the public, driven by social media and mobile app advertising.

Discussion NHTW is a high-impact event which promotes HIV testing, uniting community, clinical, government and statutory stakeholders. The campaign in the future will hope to engage more partners and keep amplifying local HIV testing and raising awareness.

P093 HIV TESTING FOR HOSPITAL INPATIENTS IN A PRIORITY AREA

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10.1136/sextrans-2017-053232.138

Introduction Department of Health advises that HIV testing should be routinely offered to patients in priority areas; where prevalence ≥1–2/1000, such as Brighton. We sought to increase HIV testing in the Cardiology department. Local microbiology department advises HIV testing on all inpatients with suspected or proven infective endocarditis (IE), as such we investigated testing in this group.

Aim Assess the proportion of patients with suspected or proven IE offered a HIV test at baseline, and following an intervention to promote testing.

Methods Patients with IE are discussed at a weekly multi-disciplinary team (MDT). We retrospectively reviewed MDT meetings from June – November 2016 (cycle one). Data on HIV testing were extracted from MDT proforma and hospital results system. Initial results were presented to cardiology junior doctors and testing encouraged. We prospectively reviewed MDT meetings and HIV testing in the 10 weeks after the intervention (cycle two).

Results In cycle one, 29 patients (25 males, 4 females) had suspected or proven IE, 16 (55%) were tested. In cycle two the proportion of patients tested for HIV decreased; of the 8 patients with suspected/proven IE (6 males, 2 females); 2 (25%) were tested, 6 (75%) were not.

Discussion HIV testing rate decreased by 46% between cycles, representing multiple missed opportunities for testing. The reason for this trend is not clear but barriers to HIV testing remain, including poor awareness of indications to test, uncertainty around consent, and assumption of low risk. We plan further interventions to increase HIV testing locally.

P094 IMPACT OF AN HIV EDUCATIONAL PROGRAM ON RATES OF LATE HIV DIAGNOSIS IN AN AREA OF HIGH PREVALENCE

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10.1136/sextrans-2017-053232.139

Introduction Late HIV diagnosis is an important determinant of morbidity and mortality. An audit of new HIV diagnoses in our service based an area of high prevalence, showed high rates of late diagnosis in 2012, so an HIV education programme was implemented within the Trust. We re-audited new diagnoses in 2015 to look at the impact of the programme and compared the results.
Methods A retrospective case-note review of all newly diagnosed patients seen in our HIV clinic from 1st January 2015 – 31st December 2015.
Results 53 patients were identified in comparison to 56 in 2012, of which 64% were male compared with 55% in 2012. Median age was 41.5 years (range 21 – 68) compared with 39.5 years (range 20 – 64) in 2012. 53% were diagnosed with a CD4 count <350 cells/mm^3 compared with 63% in 2012 and 34% had a CD4 count <200 cells/mm^3 compared with 45% <200cells/mm^3 in 2012. 51% had been seen in the preceding year by doctor, compared with 52% in 2012. 49% were diagnosed in a sexual health service compared with 39% in 2012.
Discussion Our re-audit showed continued high rates of late diagnosis despite a dedicated educational programme. This suggests that education alone is not sufficient to cause a sustained impact on late diagnosis rates. HIV testing needs to be embedded in routine clinical care, such as opt out testing as advised in UK national testing guidelines, or by using pathology system alerts to suggest testing if blood results are indicative.

P095 LATE DIAGNOSIS OF HIV IN NORTHERN IRELAND

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10.1136/sextrans-2017-053232.140

Introduction Late HIV diagnoses (CD4 count <350 cells/mm^{3}at diagnosis) across UK declined from 57% (2004) to 39% (2015) however a review within our region in 2013–14 revealed much higher proportion of late diagnoses than UK average, with multiple missed opportunities for testing in majority cases. Data was presented at educational meetings and feedback given to clinicians when delay in diagnosis occurred. We sought to assess impact on late diagnoses and mortality within our population.
Methods Retrospective chart analysis of new diagnoses from March 2015–February 2016 (Period 2) to determine proportion of late diagnosis, missed opportunities for testing and mortality. Comparison made with results of previous review during July 2013–June 2014 (Period 1).
Results 76 new diagnoses during period 1; 71 in period 2. Late diagnosis decreased from 59% (45/76) to 49% (35/71). Proportion diagnosed through GUM increased from 20% to 34%. Remainder diagnosed in other specialities, most commonly general medicine. Mode of transmission in period 1 and 2 respectively; MSM 49% vs71%, heterosexual 47% vs 23%, IVDU 7% vs 11%. Prior to diagnosis, number patients presenting to other settings with clinical indicator diseases significantly decreased from 84% (38/45) in period 1 to 49% (17/35) period 2. Mortality more than halved from 7% (4/45) in period 1 to 3% (1/35) period 2.
Discussion While there has been a decrease in number of late diagnoses and mortality rate, the proportion being diagnosed late remains higher than other UK regions. Opportunities for early testing are still being missed and ongoing education required.

P096 HIV TESTING IN TERTIARY HEALTHCARE SETTINGS – STAFF BELIEFS AND CONCERNS

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Introduction Undiagnosed HIV remains a problem in the UK. Locally, we have an extremely high prevalence of HIV (>8:1000). BASHH, BHIVA and NICE recommend routine HIV testing in medical admissions in areas of high prevalence. We wanted to identify current practices and knowledge of HIV testing in our large acute urban hospital trust.
Methods An electronic survey of clinical staff was distributed via email and Trust website in November 2016.
Results 42 responses were collected from 21/42(50%) nurses, 6/42(17%) medical staff and 15/42(36%) other staff. 33/42 of responses were from non-traditional settings (non-GUM, HIV, ID). 39/42(93%) agreed that HIV testing should be part of regular healthcare and most (32/42(76%)) agreed that it does not interfere with other healthcare services and (24/42(57%)) that they have the resources to perform a test 30/42 (75%) feel comfortable in discussing HIV with patients and 20/42 (71%) feel comfortable in offering and performing an HIV test. 18/42(43%) said they believed patients would be offended by offering an HIV test. 14/42(34%) do not know if patients receive adequate pre-test information, while 20/42 (48%) said patients are not receiving adequate post-test information. 17/42 (41%) do not know if test results are being given in an appropriate and confidential manner to patients.
Discussion Overall clinical staff believe that HIV testing is a good idea and does not interfere with the provision of regular health care services. However the clinical teams offering tests need more information on what pre and post-test discussion is required and how patients receive results.

Improving Clinical Practice and Service Delivery

P097 ABSTRACT WITHDRAWN

P098 EVALUATION OF THE PERFORMANCE OF HCV AG IN ROUTINE SCREENING FOR HEPATITIS C IN HIGH-RISK POPULATIONS

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Introduction Screening high-risk populations for hepatitis C (HCV) using antibody (anti-HCV) does not immediately distinguish resolved and active infections and may miss acute infections. HCV core-antigen (HCVAg) screening has been introduced in laboratories supporting some UK sexual health clinics. We evaluated Abbott Architect's automated HCVAg immunoassay for HCV screening.

Methods Testing was introduced in May 2015 for those reporting HCV risk in the past 6 months, and annual screening for all HIV-positive individuals. HCVAg-positive samples were tested in duplicate, then tested for HCV–RNA. Few samples were tested for both HCVAg and HCV-RNA in the initial few months. Results for all tests performed May 2015–April 2016 were reviewed.

Results 5132 samples were tested for HCVAg. 113/5132(2%) were HCVAg positive. 139 samples had both HCVAg and HCV-RNA tested. Using HCV-RNA as the gold standard, HCVAg sensitivity was 99%; positive predictive value 63%. Specificity was 39%; negative predictive value 96%.

Abstract P098 Table 1 Evaluation of HCV Ag test

	HCV-RNA detected	HCV-RNA not detected
HCVAg+ve	71	41**
HCVAg-ve	1*	26

The HCVAg negative/HCV-RNA positive individual had low viral load (130c/ml).

Of the 41 HCVAg positive/HCV-RNA negative individuals; 30(73%) were retested later and were HCVAg negative and HCV-RNA or anti-HCV negative. 3(7%) were persistently HCVAg positive but HCV-RNA negative; 7 had no follow up samples; 1 subsequently became HCV-RNA positive.

Discussion The specificity of HCVAg in our cohort is lower than that published in a recent systematic review (93% sensitivity/99% specificity). False positive results cause distress for patients and additional laboratory costs, however the increased sensitivity for acute infection may lead to earlier diagnosis in high-risk populations.

P099 TV OR NOT TV: USING NAATS TO IMPROVE THE COST EFFECTIVENESS OF TESTING

Audit of the management of patients with trichomonas vaginalis, using nucleic acid amplification technique (naat) testing in a high tv prevalence area

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Introduction In April 2016, we changed from TV culture to BD Viper NAATs testing and from testing all women to only testing women who were symptomatic, STI contacts, had previous TV and male contacts of TV.

Methods Laboratory data and SHHAPT codes retrospectively identified all patients diagnosed with TV between 1 May – 30 November 2016. Electronic patient records (EPR) were reviewed and data analysed in Excel.

Results There were 96 new diagnoses, 93 females and 3 males, median age 31 (IQR 24–40). 66% Black Afro-Caribbean; 3 were sex workers. 91% symptomatic, 22% had STI co-infection, 26% bacterial vaginosis, 7% candida and 32% previous TV.

Wet prep microscopy (WPM) detected 65% of symptomatic cases. Treatments were Metronidazole or Tinidazole.

The audit standards our service achieved (BASHH performance standards target- 97%) were: 100% received appropriate antibiotics, 51% written information receipt documented, 90% had partner notification recommended (PN) and 28% PN confirmation.

Abstract P099 Table 1 Cost analysis summary

	2015 (Culture)	2016 (NAATs)
Tested	3054	1859
Positive	84	117
New infections	73	96
Cost	£19,851	£15,486

Discussion TV NAATs cost more than culture but changing our protocol reduced the overall cost while increasing the number of new diagnoses; enabling us to target testing to patients at highest risk. 35% (27) were missed on WPM. 9.3% (9) were asymptomatic and detected because of testing as contacts of TV/sex worker/cervical cytology detection. Recommendations include: staff training to improve completion of PN and modifying our EPR fields to improve documentation of leaflets having been given.

P100 PRIME: A WEB-BASED HIV RISK REDUCTION PACKAGE FOR HIGH-RISK MSM

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Introduction Previous work has shown that HIV-negative MSM with the following characteristics attending our service have approximately a 10% chance of acquiring HIV in the following 12 months: rectal bacterial STI, early syphilis infection, previous PEP use. In May 2016, we introduced a web-based support package, PRIME, targeting such high-risk MSM to reduce their HIV risk and encourage more frequent STI testing with the aim of reducing their risk of HIV acquisition to below 5% per year.
Methods Notes review of the first 50 MSM recruited to PRIME between 19th May 2016 and 7th June 2016.
Results By the end of 2016, 1531 eligible MSM had joined PRIME. No one had left the service. Of the first 50 PRIME recruits, median age was 32 years. Median number of partners in the preceding 3 months was 5. Indication for joining PRIME was documented in 45 (39 PEP, syphilis 2, bacterial rectal STI 1, 2+ indications, 3). In the preceding 12 months 15 had been diagnosed with chlamydia and 10 with gonorrhoea. To 31st January 2017, there is 18.8 person-year follow up for these individuals. The average frequency of STI screens per recruit increased from 2.7 to 7.1 per person-year follow-up. During follow-up the number of infections was: 7 chlamydia, 4 gonorrhoea. One individual tested positive for new HIV infection, 10 weeks after joining PRIME.
Discussion The results show it is feasible to engage significant numbers of high risk MSM clinic attendees using online interventions such as PRIME. Early data suggests that the intervention has successfully increased STI screening in this group. Further follow up is required to see if the initiative has achieved its aim of reducing HIV seroconversion to below 5% per year.

P101 CUTTING THE TIME TO TREATMENT OF CHLAMYDIA TRACHOMATIS (CT) AND NEISSERIA GONORRHOEAE (NG) WITH NEAR-PATIENT MOLECULAR DIAGNOSTICS: THE UTILITY OF THE CEPHEID GENEXPERT SYSTEM

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Introduction The Cepheid GeneXpert® provides near-patient molecular detection of CT/NG, with results available in 90 minutes. Previous studies have illustrated the benefits to asymptomatic individuals and their partners in reducing time to treatment.
Methods A case-control study was undertaken to investigate the impact of introducing GeneXpert to a Level 3 symptomatic service. 100 patients diagnosed with CT+/-NG before and after introduction were identified. Time from attendance to treatment was measured. Using self-report over the previous three months and assuming that rate of new sexual partners remained the same and spaced equally in time, we modelled the number of partners spared exposure due to earlier treatment of CT/NG.
Results Characteristics of the study populations, and of the time to treatment and partners spared analyses are shown in the table:

Abstract P101 Table 1 Time to treatment

	Pre-implementation of GeneXpert (n=100)	Post-implementation of GeneXpert (n=100)
Male (%)	40	61
Age (median [range])	28.1 [15–69]	30.6 [14–70]
MSM/WSW (%)	33/0	37/1
Symptomatic (%)	50	28
Time to treatment (days (mean) [SD])	9.5 [13.23]	3.3 [4.94]
Sexual partners in preceding 3 months (mean [SD])	2.1 [1.71]	4.0 [10.48]
Partners exposed in interval between test and treatment/100 index cases	19.9	9.12

The time from testing to treatment was reduced by 6.2 days. The number of partners exposed/100 index patients was 19.9 pre-GeneXpert and 9.12 post-GeneXpert.
Discussion Use of GeneXpert reduced time to treatment by 66%, and 54% fewer partners were exposed to CT/NG. This study supports the personal and public health benefits of innovative, near-patient molecular diagnostics coupled with effective recall mechanisms.

P102 INTEGRATION OF CLINIC SERVICES WITH ONLINE SEXUALLY TRANSMITTED INFECTION (STI) TESTING (SH:24) IN CAMBERWELL, SE LONDON: IMPACT OF ACTIVE REFERRAL OF ASYMPTOMATIC TESTING ONLINE IN 2016

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10.1136/sextrans-2017-053232.146

Introduction An online service was implemented in an area with high burden of sexually transmitted infections and poor sexual health outcomes. The aim was to improve access and availability of sexual health, fully integrated within NHS services. This study looks at the impact of a change in management, whereby asymptomatic patients seeking STI testing in the GUM clinic were directed to the online service.
Methods We compared clinic attendance in 2016 before (quarter 2, Q2) and after (quarter 3, Q3) the change in clinical practice. Individual level clinic attendance data were collated and summarised as simple STI test performed (chlamydia, gonorrhoea, HIV, syphilis) or complex service required. We also compared service use by age, ethnicity and sexual orientation. Changes in pattern of clinic attendance between the quarters were analysed using a Chi^2 test.

Results

Abstract P102 Table 1 Changing pattern of GUM clinic use.

	Q2 (Before)	Q3 (After)
Total visits (valid code)	6,949	5,397
Simple STI test	4,044 (58%)	2,823 (52%)
Complex service	4,785 (69%)	4,083 (76%)
Complex service & simple STI test	2,845	2,170

There were significantly fewer simple STI tests (Chi-squared, $p<0.001$) and more visits requiring complex services ($p<0.001$) in Q3 versus Q2.

Discussion Following establishment of efficient online STI testing, the clinic changed its triage practice: asymptomatic patients seeking STI testing were directed to use the online service. The change appears to facilitate a higher proportion of more complex visits although the absolute number of visits has decreased.

P103 A PSYCHOSEXUAL NEEDS ASSESSMENT OF PATIENTS ATTENDING FIVE LONDON SEXUAL HEALTH CLINICS

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10.1136/sextrans-2017-053232.147

Introduction The aim of this psychosexual needs assessment was to investigate the prevalence and range of sexual problems; to understand the distress, causal attributions and functional impairment associated with these; and to explore patients' service-related needs, in a sample of patients attending sexual health clinics in London.

Methods Questionnaires were disseminated to patients attending five sexual health clinics in London, over a one week period. Nine hundred and thirty four patients responded to the questionnaire. Patients were aged 29.4 years ($SD=8.8$) and predominantly female (61.4%).

Results 31.1% of patients indicated they were experiencing a sexual problem. Premature ejaculation, delayed ejaculation, or difficulty having an orgasm were the most prevalent problems reported by patients (13.5%). Female and male patients did not differ in their report of overall sexual problems (32.5% and 28.6%, respectively), however more women reported sexual pain (14.8%, $X^2=11.3$,$p=.001$) and male patients reported difficulties with hypersexuality (9.5%, $X^2=25.2$,$p<.001$). The majority of sexual problems had commenced within the past year, however orgasm, chemsex and hypersexuality problems were longer-standing (>1year). Associated distress was reported by 79.5% of patients. Emotional reasons were attributed as the most likely cause of sexual problems (21.1%). Male patients reported higher functional impairment ($U=1862.0$, $z=2.3$, $p=.02$). Patients were interested in a range of interventions, and expressed preference to be supported in a sexual health clinic (67.8%).

Discussion The findings present implications for the provision of psychosexual services in sexual health clinics.

P104 SELF-SERVICE SEXUAL HEALTH: PIPEDREAM OR REALITY?

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10.1136/sextrans-2017-053232.148

Introduction Finding smarter ways of working which meet the needs of increasingly IT-savvy clients and support their busy lifestyles is a priority and an opportunity to innovate.

To meet these demands, we developed a national web-based hub, streamlining access to sexual health information and local services, while signposting to services nationally. User insight helped inform the design which was mobile first.

Methods Following launch of the hub, we recorded a number of metrics to assess acceptability to users and impact on existing services.

Results In the first 5 months of operation we have seen: 45% more people visiting our national website than all local websites combined, with users staying longer and engaging with well-being content. 75+% accessing from a mobile device. Peak use in 18–34 year olds, with all age groups represented. 151% increase in visits to LARC self-help online content and use of pre-consultation videos. 10% reduction in call volumes to services, equating to 213 hours of admin time. Improved patient experience and choice as evidenced through user survey. Very easy or easy to find information and advice online: 92%. Very likely or likely to recommend to a friend: 96%

Discussion Initial results are encouraging and suggest the online hub is acceptable and helpful to users. Increasing available self-management options in the next phase of this project will include free postal sampling kits for asymptomatics (aged 16+), with the aim of increasing access to screening, reducing unnecessary clinic visits and releasing capacity in services for those requiring clinician input.

P105 CHARACTERISTICS OF FREQUENT ATTENDERS AT A CENTRAL LONDON SEXUAL HEALTH SERVICE

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10.1136/sextrans-2017-053232.149

Introduction BASHH guidance recommends screening for STIs up to every 3 months for individuals at risk of HIV. Conversely, commissioning pressures aim to reduce inappropriate attendances. We describe below the characteristics and outcomes of frequent attenders at our service.

Methods Notes review of individuals with 4 or more new or re-book attendance episodes at a central London sexual health service between 1st April 2015 and 31st March 2016.

Results 170 individuals received more than 4 new episodes of clinical care in a year; 145(85%) were male, 136 MSM. 21 (12%) were female, 4(2.4%) transgender. 23(14%) of the patients were HIV positive, all MSM. Median age was 31 years. Median number of sexual partners in preceding 3 months was 6. 75(44%) disclosed chemsex activity in the preceding month.

In the 12 months from April 2015, there were 442 new STIs in this population, an average of 2.6 per patient: 346 STI diagnoses were in the 147 HIV-negative individuals and

96 in the 23 HIV-positive individuals. In HIV-negatives, the diagnosis was a rectal bacterial STI in 36% and syphilis in 7%. 206 courses of PEP were prescribed; 25 individuals received 4 or more PEP courses. There were 5 new diagnoses of blood borne virus infections; 2 hepatitis C, both in HIV positive MSM, and 3 HIV.

Discussion The majority of frequent attenders at our clinic had indicators of high risk sexual behaviour. The high number of STIs and PEP prescriptions implies that the frequent attendances are appropriate in this patient population.

P106 THE INBETWEENERS: 16 & 17 YEAR OLDS ATTENDING SRH ARE VULNERABLE

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10.1136/sextrans-2017-053232.150

Introduction Legally, 16 and 17 year olds can consent to sex but may still be vulnerable to sexual exploitation; opportunities to identify vulnerability may be lost when transitioning into adult services.

Methods In the financial year 2015–16 there were 1975 attendances of 998 individuals <18 at a sexual & reproductive health service. A risk assessment proforma was used in 98.8% (n=505/511) of those 16 or under and 72.9% (n=355/487) of those aged 17. These were analysed using an electronic report.

Results Discussion Using a risk assessment proforma with **16 and 17 year olds enabled** staff to recognise vulnerabilities related to child sexual exploitation, 53% of all concerns were among this age group. When transitioning to online and adult services care models **should include assessment to identify** vulnerabilities such as pre-existing i**nvolvement with social care, older partners & mental health difficulties. Staff should be competent in managing** disclosures and have a **working knowledge of social care, referral thresholds and pathways within local networks for those at risk of CSE.**

P107 EXPLORING THE AWARENESS AND ACCEPTABILITY OF SCREENING METHODS FOR ANAL INTRAEPITHELIAL NEOPLASIA (AIN) IN THE HIV-POSITIVE MEN WHO HAVE SEX WITH MEN (MSM) POPULATION

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10.1136/sextrans-2017-053232.151

Introduction Rates of AIN and anal squamous cell carcinoma (SCC) are increasing worldwide, particularly within high-risk populations, such as HIV-positive MSM. Although screening programmes for AIN exist, evidence supporting their benefit is currently limited and ongoing studies will provide crucial data regarding their efficacy.

Aim(s)/Objectives To determine awareness of AIN and acceptability of potential screening methods in a large HIV-positive MSM cohort with high rates of anal SCC, to assist in the development of future services and to evaluate a patient information leaflet.

Methods A patient information leaflet was designed providing information about AIN and screening methods. Respondents read the leaflet and completed a survey determining both its usefulness and attitudes towards screening services.

Results 172 HIV-positive MSM completed the survey with a modal age-range of 45–54. 146 (84.9%) read the leaflet and found it useful. Though only 23 (13.4%) were previously aware of AIN, 119 (69%) were concerned. 23 (13.4%) self-examined regularly though 88 (51.2%) were not aware of self-examination. However, 119 (83.2%) were willing to self-examine and 142 (99.3%) would accept examination by a healthcare professional. Support for a screening programme was strong with 143 (83.1%) of respondents stating they would be willing to participate.

Discussion In this well-informed HIV-positive MSM population, awareness of AIN and screening methods is low, however self-examination and screening is acceptable. It appears that our information leaflet is a useful tool to raise understanding and promote self-examination.

Abstract P106 Table 1 The inbetweeners

	Under 16 n=205	Age 16 n=300	Age 17 n=355
New safeguarding concern	14 (7%)	8 (4.3%)	8 (3.8%)
Known to social care	52 (34%)	61 (20%)	70 (20%)
> 10 sexual partners	2 (1%)	9 (3.2%)	14 (4.2%)
Age of current or last partner 18–24 years	9 (4.3%)	66 (23.8%)	195 (58.9%)
Age of current or last partner 25 years or >	0	4 (1.4%)	5 (1.5%)
Mental health difficulties	47 (23%)	63 (21%)	93 (26%)

P108 CLOSING THE AUDIT CYCLE AFTER UPDATED PROCTITIS GUIDELINES: ARE WE TREATING TOO MUCH OR TOO LITTLE?

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10.1136/sextrans-2017-053232.152

Introduction There are currently no national guidelines for the management of proctitis. Given the rising rates of STI's, we modified our current guidelines and audited the outcomes pre and post-guideline change.

Methods Retrospective case note analysis was performed on all patients who were coded as proctitis (C4NR) before and after the guidelines were modified. We collected information on demographics, HIV status, symptoms, investigations, treatment and outcomes.

Results We returned 64 patient records over 67 visits, 39 pre and 25 post-guideline changes. 31% (20/64) were HIV positive. Commonest presentations were PR bleeding (49%), rectal discharge (44%) and diarrhoea (28%). 55/64 (88%) had rectal microscopy, with 42/55 (76%) having pus cells present; of these 3/42 (7%) had GC seen on microscopy. There were very low levels of urethral STI rates (just one case of each), but high rates of rectal GC and CT (24% and 13% respectively). LGV was positive in 5% (3/54) and rectal HSV was found in 25% (10/40). There were more HSV swabs sent before versus after guideline modification (19/40 versus 21/27, p=0.01).

Discussion The audit has shown that the addition of HSV swabs and treatment into the guideline had a positive effect, with more cases of HSV proctitis being diagnosed and treated. Our guidelines were also modified to include LGV treatment, but given the low prevalence this may be rationalised. Ongoing work around coding is also planned as many were coded as proctitis without rectal microscopy.

P109 ROUTINE HEPATITIS C ANTIBODY TESTING IN MSM – ARE WE OVERTESTING?

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10.1136/sextrans-2017-053232.153

Introduction The hepatitis C virus (HCV) is rarely transmitted sexually. MSM with HIV are at increased transmission risk. Debate exists regarding sexual transmissibility of HCV in those without HIV or additional risk factors beyond receptive anal intercourse. Following outbreaks of HCV in Europe and London in MSM, Oxfordshire Sexual Health Services introduced annual unselected HCV antibody testing as a screening minimum for all MSM. Evidence now suggests this may not be necessary. We set out to audit our HCV testing to assess this and identify potential policy modification.
Methods We reviewed all HCV antibody tests undertaken in a 12 month period. We identified all HCV positive patients to determine risk factors for infection in order to establish whether these patients were identified through annual screening or would have been identified using a selective basic risk analysis.
Results We found 13 positive results out of 1351 tests. 6 had previously known HCV, 4 were co-infected with HIV. 2 were heterosexual men with additional risk factors, one was an MSM with additional risk factors. No HIV negative MSM with HCV infection were identified through annual screening alone. Approximately 3.5% of tests undertaken were based on recognised risk factors for HCV, 96.5% were undertaken as part of annual screening. This equated to £1486 per new diagnosis, excluding service costs.
Discussion Routine annual screening of HIV negative MSM in this study did not pick up any new HCV diagnoses. Cost per diagnosis may be reduced with targeted testing. The annual screening policy needs modification.

P110 WORKING SMARTER BY INCORPORATING ONLINE TESTING: MAXIMISING SELF-MANAGEMENT OR OPENING AN ADDITIONAL CHANNEL? A TWELVE MONTH REVIEW

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10.1136/sextrans-2017-053232.154

Introduction We reviewed how the introduction of online access to sexually transmitted infection (STI) testing for a county wide sexual health service has affected face to face (F2F) attendances, and overall attendance numbers.
Methods As part of managing a large county wide integrated-sexual health service we have based our planned attendance numbers on actual activity data from previous years to forecast service activity. In April 2016 we introduced the option of online STI access alongside a complementing triage system. Using electronic record and online access data we compared actual to projected activity, and established the effect of the online service in terms of overall activity for 2016/17.
Results The introduction of an online channel together with a reviewed triage system appears to have directly reduced F2F attendances. The overall activity level including both F2F and online for the service did rise, but based on the cost of F2F attendance compared with theaverage cost of online tests, there are still estimated savings of over £500,000 and predicted reduction of around 10,000 F2F attendances.

Abstract P110 Table 1 F2F and Online testing

Service	Activity plan 2016–17	Activity actual 2016–17 (based on quarters 2 and 3 extrapolated)
F2F	59410	49398
Online access	4654	17118
Total	64064	66516

Discussion People have been satisfied with the online service and it appears to be an acceptable and popular alternative and not and addition to F2F. The reduction in F2F attendances (10,000) frees up clinical time enabling improved and increased resource for complex care and staff and service development.

P111 REACHING OUT – GUM IN THE GENERAL PRACTICE SETTING

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10.1136/sextrans-2017-053232.155

Introduction Providing accessible GU services in rural areas is difficult. Providing a service in General Practice (GP), close to patients' homes may increase access (particularly to those who might not otherwise test) and avoid the perceived stigma of attending a GUM clinic. A GUM service was set up in 2008 within a general practice setting (syndromic management), in an area of high need (HIV prevalence 2.58 PHE 2015).We aim to describe the outcomes of running a GU clinic within GP.
Methods Demographic, attendance and diagnoses data was collected and analysed from 2008–2016.
Results A total of 1081 patients were seen (1826 attendances) with a median of 200(186–221) per year. 604 diagnoses of infection were made (33.1%). 922(85%) lived in the town where the clinic was held. 53.8%(582) had never been seen in GU in our county before compared with 32.6% in the hubs. 440 (41%) were men of which 40(9%) were MSM. Mean age for attendees was 29 (28 at the main GU hub). Total number <20 year olds fell from 2007-2016 but those aged 21–35yrs and 45–60yrs increased. Table 1 shows the distribution of GUMCAD diagnoses. There were 426 DNAs (18.9%), 42% were follow-ups. Overall HIV testing was refused in 15.5% cases, (30% in 2007 but 7% in 2016).

Discussion In rural areas where transport links are limited, a GU clinic run in GP offers an efficient, anonymous service. Services can be offered in this setting with few extra resources providing an alternative point of access for patients.

Abstract P111 Table 1 GUM in general Practice

Diagnosis	n=604	% all diagnoses	% all patients	% attendances
Chlamydia	190	31.4%	**17.5%**	10.4%
Gonorrhoea	7	1.2%	0.6%	0.4%
Syphilis	1	0.2%	0.09%	0.05%
HIV	1	0.2%	0.09%	0.05%
Other	406	67.0%	37.6%	22.2%

P112 RETROSPECTIVE STUDY OF THE RESULTS OF TAKING OF BLIND SWABS VERSUS SPECULUM-ASSISTED SWABS IN WOMEN WITH VAGINAL DISCHARGE

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10.1136/sextrans-2017-053232.156

Introduction Although a speculum is generally recommended to aid the taking of swabs for microscopy in women with vaginal discharge, many women dislike this and ask for a blind swab, in which a plastic loop is inserted high into the vagina to take a sample. We have agreed to this for some women and have therefore retrospectively looked at the diagnostic rates for each method.
Methods We looked at 150 consecutive women clinically coded as 'TS' (microscopy performed) in 2015 and 2016 and looked at the proportion of women tested by each method and the vaginal-discharge-causing infections diagnosed.
Results In 2015, 129 women had clear documentation of the method used of which 120 (93%) where speculum-taken and 9 (7%) were 'blind'. In 2016, of 101 women with documentation of the method used 52 (51%) were speculum-taken and 49 (49%) were 'blind'. The diagnostic rates for each infection are given in the table.

Abstract P112 Table 1 Blind.v. speculum testing

Method used to take sample	Total number of women tested by each method	TV	BV	Candida	BV + Candida
Blind	58	3 (5%)	18 (31%)	9 (16%) *	0**
Speculum	172	8 (5%)	75 (44%)	58 (34%)*	24**

* P=0.008 ** P=0.0001

Discussion The blind swab method appears to be accurate in the diagnosis of TV and possible BV, but is clearly inferior in the diagnosis of candida and mixed candida/BV infections.

P113 DOMESTIC VIOLENCE – DO WE ASK? WILL THEY TELL?

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Introduction Experience of domestic violence is reported as 28.3% in women and 14.7% in men. It causes significant harm and screening sexual health clinic attendees is recommended. Proformas used within our service include a question on domestic violence however screening practice among clinicians varies.
Aim Investigate the prevalence of domestic violence among our clinic attendees and determine if current practice is successful at identifying this.
Methods Patients attending a clinic on 9th January 2017 were asked to complete an anonymous questionnaire including questions on domestic violence, mental health, unplanned pregnancy and STI's. A retrospective audit of documentation of domestic violence in patient's records was then undertaken for all patients attended on that day.
Results Total number of attendees on 9th January was 111, 57 completed questionnaires (52% female and 50% male attendees). Domestic violence was reported by 27% female attendees and 16% male attendees (10% in heterosexual male, 33% in MSM). Females suffering domestic violence more commonly reported sexual assault, mental health problems and unwanted pregnancy.

34% female attendees had a documented enquiry regarding domestic violence. 24% of these reported domestic violence. Among male attendees 38% had a documented enquiry with 9% reporting domestic violence. Reporting of domestic violence by men to clinicians was lower than predicted by the survey.
Discussion With our current practice we can expect to miss 10 women and 5 men a day who have suffered domestic violence. Routine enquiry is to be recommended. Reluctance to disclose domestic violence may still be a barrier to identifying this hidden problem.

P114 SENSITIVITY AND COST-EFFECTIVENESS OF TRICHOMONAS VAGINALIS NAAT (NUCLEIC ACID AMPLIFICATION) ASSAY IN SYMPTOMATIC FEMALE PATIENTS ATTENDING A GENITOURINARY MEDICINE CLINIC

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Introduction Trichomonas vaginalis is the commonest curable sexually transmitted infection worldwide. Diagnosis is by detecting Trichomonas organisms or its DNA. Sensitivity of microscopy in females is 45–60%. Culture has a higher sensitivity than microscopy but molecular detection offers the highest sensitivity and is considered gold standard. We currently use only microscopy and this may lead to false negatives. This study assesses sensitivity and cost-effectiveness of TV NAAT assay compared with microscopy and acridine orange (AO) staining in symptomatic female patients.
Methods Prospective study looking at symptomatic female patients attending sexual health clinic during the period from 05/10/2015 to 17/05/2016.Female patients with one or more of the following symptoms; vulval soreness, itchiness, ulceration or abnormal discharge were included. Wet microscopy was performed and dried slide was sent to the lab for AO staining. TV NAAT was added to the Chlamydia/Gonorrhoea dual testing swab.

Results 452 patients were included. Age ranged from 14–65 years. 31,18 and 8 patients had positive NAAT, microscopy and AO respectively. Considering NAAT as the gold standard; sensitivity, specificity, PPV and NPV of microscopy and AO was 48%, 100%, 100%, 95% and 28%, 100%, 100%, 94% respectively. 51.6% of the cases would have been missed if only the microscopy was used to diagnose TV.
Discussion Overall prevalence of TV positivity in our study population was 7.52%.Microscopy provided the advantage of rapid result but failed to identify half the positives.TV NAAT testing in carefully selected symptomatic women will be of value to provide better patient care.

P115 SIX YEARS OF OUTREACH TESTING- DOES IT WORK?

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Introduction We have been running an outreach program since January 2009 in order to target high-risk MSM using sex on premise venues.
Methods Monthly outreach sessions to high-risk venues, inc annual pride events, run in conjunction with a LGBT organisation. Patients offered serological testing for HIV, syphilis, hepatitis B and C, triple site testing for Chlamydia/Gonorrhoea PCR and vaccination for hepatitis A and B.
Results Over 6years, 79 outreach sessions held, with 1305 assessments. 226 patients have attended more than once. 424 (68%) patients had never previously attended GUM and 391 (62%) had never had HIV testing. Testing found 13 HIV, 61 untreated syphilis (46 early), 4 chronic active hepatitis B, 63 Chlamydia (21 UR, 36 rec, 6 Th), 48 gonorrhoea (3 UR,18 rec, 27 Th). All patients attended for follow up at GUM clinic. HIV never testers decreased from 34% 2009 to 14% 2014. Vaccines given 160 in 2009, 40 in 2014.
Discussion The outreach program is a very important initiative, reaching high risk men who very often would not have been tested (34% in 2009). There was a high rate of infection diagnosed. Over time less vaccines required, percentage of HIV 'never testers' dropped 34–14% and 6mthly testing increased 13–45%. The outreach has increased access and raised the profile of the health services offered by GUM.

P116 OUR NEW STATUTORY OBLIGATIONS UNDER THE AMENDED FEMALE GENITAL MUTILATION ACT 2003 (SECTIONS 70–75 OF THE SERIOUS CRIME ACT 2015); ONE YEAR ON

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Introduction The UN estimates 200 million women and girls worldwide are living with the effects of female genital mutilation (FGM), with 137,000 victims in England and Wales. Following the introduction of the amended FGM Act 2003 in October 2015, I reported that 1385 new cases were identified in England in the quarter before the new law and 1316 in the quarter following. In keeping with my aim, I have reviewed the data from the year following the new legislation, to determine its effect.
Methods Using hscic and NHS digital data, combined with reports from UN and WHO, I analysed the 12 months following the legislation change. I also searched Ministry of Justice reports to study how many FGM protection orders (FGMPOs) and convictions have been made.
Results Data revealed similar numbers of new cases of FGM reported in each 3-month period since October 2015 (1242, 1293 and 1204 respectively). However, there are large gaps in the data. Since July 2015, there have been 97 applications for FGMPOs and 79 orders. There have still been no FGM related convictions in the UK, despite 32 cases being reported to have happened in the UK between January and September 2016.
Discussion The results are disappointing and we are yet to see substantial change. £4million has been spent and 22,000 FGM training sessions have been delivered but we are still failing to report properly and prosecute offenders. To achieve 2015's Sustainable Development Goals, the UK must play its part to help end FGM.

P117 A REVIEW OF SEXUAL HEALTH PROVISION AT COASTLINE HOMELESS DAY CENTRE

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Introduction
Homelessness goes beyond rooflessness It is isolating and destructive. The government recognises the homeless are more vulnerable to sexual health risks and need targeted interventions. Cornwall's sexual health outreach is limited.
Methods A fortnightly afternoon drop-in sexual health clinic, run by a senior nurse and healthcare assistant, was established in a Health-for-the-Homeless (HFH) General Practice service in a socially deprived area of Cornwall. Shared-care with the HFH service whereby patients gave permission for results to be copied to the GP service.
Results Between September 2013 and January 2017, there were 498 clinic attendances, with 109 (22%) females, and 389 (78%) male clients. Of all attendances, 181 (36%) accepted sexual health screening. Of these, 17 (9.4%) were diagnosed with a sexual infection and/or hepatitis C, including 7 (3.9%) of chlamydia; 4 (2.2%) of new hepatitis C infection; 3 (1.6%) of genital warts; and 1 (0.6%) of: gonorrhoea, herpes and molluscum contagiosum. All infections were treated. 5 (5%) females had cervical cytological assessment. A 140-strong sample of notes were scrutinised to ascertain examination uptake. Of 82 indicated examinations, 26 (32%) accepted, 56 (68%) clients declined. Poor uptake may account for the low rate of skin conditions diagnosed. 20 (4%) attendances culminated in vaccination. The clinic managed 3 (0.6%) recent sexual assault cases.
Discussion Client feedback suggests that medical help would not have been sought elsewhere. Meeting in a safe environment, we believe we have broken down barriers. An increasing number of returning clients we hope reflects trust in the service. Service costing will be discussed to develop contraception provision.

P118 PATIENTS' SATISFACTION WITH MEDICATION INFORMATION PROVIDED BY NURSES USING INDEPENDENT NURSE PRESCRIBING (INP) OR PATIENT GROUP DIRECTIONS (PGDS) IN UK SEXUAL HEALTH SERVICES

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10.1136/sextrans-2017-053232.162

Introduction Nurses' ability to independently deliver medication was introduced to improve patients' access to medication and experience of healthcare services. INP and PGDs are used frequently in sexual health services; however, there is limited evidence of patients' satisfaction with medication information provided.

Methods Nurses (INP or using PGD) from five UK sexual health services distributed a questionnaire to patients with whom they had consulted and delivered medication, Sept 2015 – Aug 2016. The questionnaire was informed by Birmingham's sexual health service satisfaction questionnaire and the Satisfaction with Information about Medicines Scale (SIMS).

Results Of the 393 patients who received a questionnaire, 92% (n=360) responded. Patients who had received medicines via a PGD and INP reported nurses to be friendly and approachable (n=359/360, 99%); that they installed confidence and trust (n=357/360, 99%); explained the reasons for medications clearly (n=349/360, 97%); and suitably answered questions (n=335/360, 93%). Of the 89% (n=348/360) of respondents who completed the SIMS, an overall score of 13.3/16 was achieved: the higher the score, the greater the satisfaction. The largest points of dissatisfaction related to not receiving information on whether they could drink alcohol (n=58/348, 17%), potential for drowsiness (n=54/348, 16%) or side effects (n=37/348, 11%).

Discussion Patients predominantly provided positive feedback regarding their medication consultations with nurses. High SIMS scores identified overall satisfaction with medication information. Further consideration may be needed on the potential problems medications can cause to further improve patient satisfaction (e.g. advice on alcohol consumption, side effects and drowsiness potential).

P119 A COMPARISON OF THE CLINICAL SAFETY OF INDEPENDENT NURSE PRESCRIBING (INP) AND USE OF PATIENT GROUP DIRECTIONS (PGDS) BY NURSES IN UK SEXUAL HEALTH CLINICS

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10.1136/sextrans-2017-053232.163

Introduction Under UK legislation, nurses independently prescribe or supply medications using PGDs, but evidence on safety in clinical practice is limited.

Methods Clinical record review across five UK sexual health services, July–December 2015. Sample size quota stratified based on the number of INP/PGD practising nurses. Documented patient presentations, diagnoses, autonomy and safety/appropriateness of medication delivery were compared between INP and PGDs.

Results From 1,851 (INP=711, 38%; PGD=1,140, 62%) clinical records, 50% (n=933) involved medication delivery. INP delivered medication more frequently (INP= 385/711, 54% vs. PGD=548/1,140, 48%; p=0.01). A total of 879 medication assessments were undertaken (INP=399, PGD=480), 69% (n=609/879) were 'new' care episodes. Past medical history, concurrent medications and allergy risk assessments were recorded >85% (n=755/879) of cases. INP managed more symptomatic presentations (n=181/399, 45%: asymptomatic n=121/399, 30%); PGD managed marginally more asymptomatic (n=221/480, 46%; symptomatic n=200/480, 42%). INP worked more autonomously than PGDs (INP=310/399, 78%; PGD=308/480, 64%, p<0.01). INP most frequently managed chlamydia (n=53/399, 13%), PGDs most frequently administered vaccinations (n=80/480, 17%). Nurses delivered 66 different products, 1,351 individual medicines, azithromycin being most common (n=231/1351, 17%). Overall, 88% (n=775/879) of episodes were assessed against guidelines as 'safe and appropriate' (INP=359/399, 90%; PGD=416/480, 87%). Main reason for not 'safe and appropriate' was lack of documentation (n=56/104, 54%). PGDs were, although clinically appropriate, used outside their limits in 5% (n=24/480) of consultations.

Discussion INP deliver medications more frequently and work more autonomously than PGD users. Both groups were comparable in safe/appropriate medication delivery. Improved documentation is recommended.

P120 DETECTION OF SYPHILIS AND OTHER PATHOGENS ASSOCIATED WITH GENITAL LESIONS USING PLEXPCR

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Introduction Syphilis is an STI caused by the bacterium *Treponema pallidum* that can result in substantial morbidity and mortality. Recently, there has been an alarming global resurgence of syphilis with infections rising to unprecedented rates. As such, it is increasingly pertinent to test genital lesions for syphilis. Moreover, Herpes simplex virus types 1 and 2 (HSV–1 and HSV–2) and Varicella zoster virus (VZV) cause lesions in cutaneous and mucocutaneous sites. Recent publications have found VZV in genital specimens, suggesting that reactivation of VZV in this atypical presentation is not as uncommon as previously believed, further necessitating the importance of identifying these organisms at these sites.

Methods The PlexPCR HSV-1&2, VZV, Syphilis test (SpeeDx) is a single-well multiplex qPCR for testing genital lesions for the targets HSV-1, HSV-2, VZV and *T. pallidium*. The performance of the assay was evaluated on 90 genital specimens for which in-house PCR results for syphilis had been determined.

Results The multiplexed assay detected 54/57 syphilis positives, corresponding to a sensitivity and specificity of 94.7% and 100.0%, respectively. The assay also detected four HSV–1 and two HSV–2 infections (2 and 1 syphilis co-infections, respectively). All assays demonstrated analytical sensitivity to 10 copies per assay.

Discussion The lesion assay offers simultaneous detection and differentiation of pathogens that cause genital lesions. In response to the current emerging syphilis outbreak, this assay could provide a rapid and effective method of determining the infectious agent responsible for genital lesions, supporting earlier detection and rapid treatment to reduce morbidity or worse outcomes.

P121 CHOOSE TO TEST

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Introduction Choice is an increasingly important element of health care. We introduced choice of test into an online sexual health service.
Methods Users were offered testing based on their risk profile (table 1) with an option to request additional tests. Routinely collected anonymised data were collected on choice of test.

Abstract P121 Table 1 Results from Choose to test

	<24	24+	BME	MSM
Genital GC/CT*	Yes	Yes	Yes	Yes
Oral GC/CT*	No	No	No	Yes
Anal GC/CT*	No	No	No	Yes
Syphilis	No	No	No	Yes
HIV	No	No	Yes	Yes

Results 2550 users ordered tests (30/10/16 – 19/12/16). 56% were <24, 10% were from black or ethnic minority (BME) groups and 17% were men who have sex with men (MSM). 1853 (72.6%) returned a test, 6.7% were positive for any STI. Of the non-BME/non-MSM users offered chlamydia/gonorrhoea testing, 66% chose to add HIV + syphillis testing. Of the BME/non-MSM users offered chlamydia/gonorrhoea + HIV testing, 71% chose to add syphilis testing. Of the MSM users offered chlamydia/gonorrhoea (genital, oral, anal) + HIV + syphilis testing, 85% chose this option. 6% chose to omit the HIV/syphilis test. User choice resulted in 611 fewer HIV tests, 596 fewer syphilis tests and 27 fewer chlamydia/gonorrhoea tests.
Discussion Online service users actively exercise choice in STI test selection. The majority of users choose to test for chlamydia, gonorrhoea, HIV and syphilis regardless of what they are offered. User choice of test reduces the total number of tests offered online.

P122 DELIVERING SYSTEM TRANSFORMATION THROUGH COLLABORATION BETWEEN ONLINE AND TERRESTRIAL SEXUAL HEALTH SERVICES

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10.1136/sextrans-2017-053232.166

Introduction Online sexual health services could shift demand for asymptomatic testing from clinics to relieve pressure and reduce cost. An online service collaborated with clinicians in two London boroughs to facilitate this through new service pathways.

One clinic developed a triage system directing asymptomatic attenders to order directly via the online service using tablets in the clinic with self-sampling packs prepared immediately to take away. Two clinics offered a 'weblink' card signposting those attending during busy periods to the online service. This study describes and evaluates these new pathways to re-direct demand.
Methods We used routinely collected testing data to analyse uptake. We compared the populations who used new pathways (weblink, 'tablet-in-clinic') with those resident in the same area accessing the online service without signposting or triage (organic users).
Results In a 6-month period, there were 8,987 orders from organic users, 1,280 orders through 'weblink' and 1,555 orders from 'tablet-in-clinic' users. Weblink users had a lower kit return rate (62.7%) compared with 'tablet-in-clinic' and organic users (71.4%; 71.9%). Positivity rates for any infection were higher among weblink (8.6%) and 'tablet-in-clinic' users (8.2%) compared with organic users (6.1%). In this period, 157 service users ordering through weblink or 'tablet-in-clinic' ordered their next test through the organic route.
Discussion Collaborative strategies to increase uptake of online services can be effective. These can increase capacity but may reduce user choice. Further work on predictive triage and targeted support for users switching service modality could enhance this offer.

P123 IS THERE A RELATIONSHIP BETWEEN THE TENDERING HISTORY OF A GENITOURINARY MEDICINE CLINIC AND ITS ACCESSIBILITY?

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Introduction Since 2004, DH guidance has recommended that GUM clinics in England should endeavour to see patients within 48 hours of initial contact. Recent changes in service commissioning and the wider adoption of competitive tendering since 2013 has led to concerns about maintaining 48-hour access.
Aim To establish whether there is a relationship between the tendering history of a GUM clinic and its accessibility.
Methods Postal questionnaires regarding tendering history were sent to lead clinicians of all 262 GUM clinics in the UK. Only questionnaires which were returned within a two-month window were analysed. Each clinic with a returned questionnaire was telephoned eight times by male and female researchers posing as patients with symptomatic and asymptomatic presentations. The researchers asked to be seen as soon as possible and recorded whether this fell within 48 hours.
Results 67 clinics (25.6%) returned their questionnaires on time. A chi-square test found no statistically significant difference between clinics tendered within the last five years (n=49) and the rest (n=18), regarding 48-hour access (86.5% and 86.2% respectively, p=0.916). Interestingly, 88% of contacts with clinics still undergoing a tender resulted in a 48-

hour appointment compared with 100% of contacts with clinics which completed the process 3–5 years ago. However, this was not statistically significant.
Discussion The negative effect of tendering on accessibility seems to be overstated. Moreover, if this effect does exist, it seems more pronounced during the actual tender, followed by an apparent boost in access. A larger study may be required to confirm this.

P124 EXPLORING HEALTH CARE PROFESSIONALS' PERCEPTIONS AND KNOWLEDGE OF TRANS* PATIENTS' SEXUAL HEALTH NEEDS: A NEED TO UPDATE THE CURRICULUM?

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10.1136/sextrans-2017-053232.168

Introduction No current competencies for transgender issues exist in genito-urinary or community sexual and reproductive health training curricula. This gap is currently being addressed and curriculum changes on the topic are being proposed. The aim of this study is to assess doctor's knowledge regarding specific trans* issues and their attitudes to proposed curriculum changes.
Methods Purposive, convenience sampling was used. A self-completed questionnaire was distributed via the British Association for Sexual Health and HIV newsletter and at the Faculty of Sexual and Reproductive Health annual conference. It consisted of 15 closed and open-ended questions on demographics, previous experience and training, knowledge of specific trans* health issues, and attitudes to curriculum changes. Analysis was done using Stata.
Results From the 110 eligible responses only 37% had received previous training on trans* issues and 81% supported adding trans* issues to the curriculum. The need for training was demonstrated in the high proportion, 86%, with concerns around managing trans* patients. Confidence was lacking in clinical scenarios, especially performing genital examinations and cervical screening. Knowledge gaps were identified in all areas, particularly regarding management of post-operative complications.
Discussion This study highlights the need for doctors' training to improve knowledge and confidence on trans* issues, as well as the positive receptivity of training. Concerns mostly revolve around how to make competencies logistically feasible in the face of an already packed mandatory curriculum and lack of opportunities for exposure to these patients.

P125 REVIEW: USE OF DIGITAL SEXUAL HEALTH SERVICES BY UNDER-16S AND AN EVALUATION OF SAFEGUARDING PROCEDURES

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10.1136/sextrans-2017-053232.169

Introduction Digital health is an increasingly popular way to access health services, particularly by young people. There is a paucity of research exploring the use of e-health services by under–16s. As an online doctor service offering sexual health services to adults, we conducted a review of under-16s trying to access services and an evaluation of safeguarding procedures.
Methods A retrospective audit of under-16s trying to access e-sexual health services between January–December 2015.
Results 66 patients were identified (a 4-fold increase since 2008). 71.2% were female and mostly distributed in urban areas.

The most frequently accessed services were emergency contraception (27.3%) and regular contraception (43.9%). 22.7% (n15) entered an incorrect date of birth. 77.3% (n51) completed a safeguarding assessment with a doctor via telephone, guided by 'Spotting the Signs', in addition to answering a questionnaire online. Safeguarding concerns were identified in 39.2% (n20) of these children and referred to social services. The remainder underwent GP follow-up. All were directed to appropriate face-to-face services.
Discussion Our data shows increasing access by under-16s to e-sexual health services. A significant proportion were identified as being at-risk of sexual exploitation. A telephone safeguarding assessment in addition to our online evaluation was an effective method for identifying safeguarding concerns. Alongside IT systems to prevent those trying to bypass checks online, many of our services (including contraception and emergency contraception) require attendance to pharmacy. The use of our pharmacy network in undertaking identity checks and face-to-face safeguarding screening is invaluable in supporting the ongoing safety of children.

P126 CHARACTERISING ADMISSIONS TO A SPECIALIST HIV INPATIENT CENTRE: DEMOGRAPHICS, DIAGNOSIS AND IDEAS FOR SERVICE DEVELOPMENT

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10.1136/sextrans-2017-053232.170

Introduction Effective antiretroviral therapy has reduced HIV inpatient admissions and patients are increasingly admitted with non-HIV related pathologies. Increasing pressure on NHS hospitals emphasise the need to minimise admissions, maintain patient flow and understand how inpatient facilities are used. We aim to review the demographics and causes of acute medical admissions to a single HIV-specialist unit.
Methods Retrospective analysis of patients admitted under the HIV team at a single referral centre including demographics, reason for admission, length of stay and discharge destination.
Results 114 patients admitted in 2016. Median age 46 years (range 18–79). 86% male. 14/114 (12%) were newly diagnosed with HIV. 24/114 (21%) admitted with HIV-associated illness, 16/114 (14%) with AIDS-defining illness, 59/114 (52%) with non-HIV associated illness. Respiratory infections were the commonest cause of admissions with 14/114 (12%) cases of PCP and 27/114 (24%) of lower respiratory tract infections. 16/114 (14%) admissions were secondary to drugs and alcohol. Median length of stay 7 days (range 1–135). Discharge destination was home 89/114 (78%), a bespoke HIV-intermediate care facility 19/114 (17%), other healthcare facility 3/114 (3%) and 3/114 patients (3%) died.
Discussion Inpatients were younger and had a much longer length of stay when compared with the average for acute internal medicine. Majority of admissions were for non-HIV associated illness suggesting adequate viral suppression for

most patients. Service adaptations are needed to address the high incidence of mental health disorders, importantly drug/alcohol addiction. We also highlight the importance of a HIV-intermediate care unit to aid rehabilitation and facilitate discharges.

P127 IS THERE A NEED FOR PELVIC ULTRASOUND WITHIN AN INTEGRATED SEXUAL HEALTH SERVICE?

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Introduction Sexual health services see a number of women who once infection is excluded, may require the use of pelvic ultrasound to aid diagnosis. Without in-house scanning facilities, they often end up on a convoluted route involving several appointments across clinical specialities.
Methods This observational study examined two consecutive years of referrals for pelvic ultrasounds from a busy integrated sexual health service, where in-house scanning was not available. Information from referrals to radiology was gathered from an imaging database where indication and outcomes were analysed from scan reports.
Results 190 patients were scanned with a mean age of 31. 184/190(97%) were outpatients. 79/190(42%) were scanned for pelvic pain, and 42/190(22%) for coil related concerns. 141/190(74%) of scans had normal findings. Of coil related referrals, only 1/42(2%) needed intervention. 19/190(10%) of pelvic ultrasounds had incidental findings not requiring follow up, and 30/190(16%) had findings requiring intervention or follow up.
Discussion In this study, all coils with 'lost threads' were found to be intrauterine – and therefore could be managed within an integrated sexual health service. Only a small number of those scanned needed onward referral or follow-up. With scanning expertise and resources, patients would be seen more quickly, with a reduction in appointments and fewer referrals. This would result in improved patient satisfaction and reduced costs to the NHS. The set-up costs would be offset in the long-term by keeping patients out of the acute setting.

P128 EXPLORING CHEMSEX IN THE NORTH EAST OF ENGLAND

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10.1136/sextrans-2017-053232.172

Introduction Recreational drug use is higher in men who have sex with men (MSM) with use of psychoactive drugs facilitating group sex sessions (chemsex). Public health implications include increased sexual risk taking with potential for HIV/STI transmission and associated physical and mental health harms. Our aims were to assess the extent of chemsex in the North East of England to inform local/national policy and tailor service provision.
Methods A regional self-administrated survey was conducted in five sexual health/HIV care providers and a local LGBT and young people's charity in the North East over a three-month period. All service users were invited to complete an anonymous paper or online survey about chemsex.
Results This is provisional data from 954 surveys. 18 respondents reported engaging in chemsex (mean age 37 years,) 71% of which took place in the North East. 94% were male and 78% of these identified as gay (17% heterosexual, 6% bisexual.) 33% were HIV positive, 60% had a previous STI and 13% were 'slamming' (injecting.) 9% of all male respondents who identified as gay, had engaged in chemsex.
Discussion Data suggests that although chemsex is relatively uncommon in the North East, it is more prevalent in the MSM population and those who are HIV positive. Screening for chemsex in these groups should be standard practice and included in UK national guidance. Consequently service provision can be tailored to address local need by simple interventions or instigate clear pathways into specialist services.

P129 DESIGNING SEXUAL HEALTH SERVICES TO MEET THE NEEDS OF YOUNG PEOPLE IN THE UK: RESULTS FROM A QUALITATIVE STUDY TO INFORM DISCRETE CHOICE EXPERIMENT (DCE) DEVELOPMENT

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10.1136/sextrans-2017-053232.173

Introduction Young people experience the greatest burden of sexually transmitted infections (STIs) in the UK. STI screening is now being provided in a wider range of settings such as GP surgeries, pharmacies, and via online services. It is important that screening provision reflects the preferences of young people from different cultural backgrounds. The specific aims of the study were: to explore the factors that are important to young people when thinking about and participating in STI screening in different settings; to examine the characteristics of screening services that influence choices about screening.
Methods Qualitative methods were used to inform the development of a discrete choice experiment (DCE) to provide quantitative measurement and analysis of the choices made by young people in relation to STIs. A series of eight focus groups and 2 interviews were undertaken with 43 young people in specialist and community settings, with the inclusion of participants from different cultural groups. Discussions were transcribed and analysed using constant comparison methods.
Results The focus groups revealed a range of aspects of screening that were important to young people. The main themes identified related to stigma, understanding of STIs and risk, setting, interactions with staff, convenience and the nature of the screening test. Attributes for the DCE were developed around waiting times, setting, type of screening test, and staff attitude.
Discussion The complexities and challenges involved in designing and delivering services for young people are highlighted, particularly in relation to reflecting the preferences of young people from varied cultural backgrounds.

P130 A COMPARISON OF DEMOGRAPHIC CHARACTERISTICS AND WORKLOADS OF INDEPENDENT NURSE PRESCRIBERS (INP) AND NURSES USING PATIENT GROUP DIRECTIONS (PGDS) IN SEXUAL HEALTH CLINICS

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Introduction Nurses legally deliver medication independently using INP or PGDs. Despite growing evidence of clinical application, there is limited sexual health research.
Methods INP and PGD nurses from five UK sexual health services completed a questionnaire, and recorded two weeks of clinical activity in a specifically designed diary, Aug 2015–Aug 2016.
Results Questionnaire response rate: 64% (61/95; INP=26/28, 93%; PGD=35/67, 52%). Respondents were mostly female (n=55/61, 90%), aged 35–44years (n=21/61, 34%). INP were mainly Band 7 or above (n=18/26, 69%), educated to Masters Level (n=16/26, 62%); PGD users were mostly Band 6 (n=24/35, 68.6%), educated to Diploma Level (n=13/35, 37%). INP had mean of 2.9 years more sexual health experience than PGD users (mean: INP=13.0; PGD=10.1years). Both groups reported access to medications was essential (n=56/61, 92%) and made their roles easier (n=60/61, 98%).

Overall 61% (INP=17/26, 65%; PGD=20/35, 57%) of questionnaire respondents completed the diary. Of the total diary entries (INP=737; PGD=593), INP managed more 'new' care episodes (n=512/737, 70%) than PGD users (n=294/593, 50%). There was no difference in medication delivery frequency (INP=460/737, 62%; PGD=348/593, 59%; p=0.16). However, PGD users required additional medication delivery support from other healthcare professionals more often than INP (INP=419/460, 91%; PGD=240/348, 69%; p<0.01). PGD users had marginally shorter patient consultations than INP (mean 22.8 vs. 24.9mins). Mean consultation support was 8mins/consultation (both groups).
Discussion Sexual health nurses require independent access to medication for their roles. INP are more likely to practice autonomously, but may spend longer with patients.

P131 AN AUDIT OF HOME TESTING KITS

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Introduction Umbrella Health recently introduced sexually transmitted infections (STI) home testing kits for asymptomatic adults from Birmingham and Solihull. An audit was undertaken to consider patient demographics, service utility and effectiveness.
Methods All patients registering for home testing kits between 1st– 10th March 2016 were included. Patient demographics, results and follow up were accessed from the laboratory and clinical database. Data was compared with a clinic comparator group of 50 randomly selected patients attending clinic during the same timeframe. Statistics were performed using Microsoft Excel.
Results 536 patients were included of which 331(61.7%) were female. 103(19%) of patients were symptomatic. 536(100%) of requested kits were distributed. 280(52%) nucleic acid amplification tests (NAAT) and 209(39%) blood samples were returned. 86(41%) returned blood samples were insufficient for analysis. 25(100%) patients with a positive result were informed via text. 10(40%) attended for treatment. 3(30%) agreed to contact tracing. Compared with the clinic attendees, users were younger (60% 16-24yrs cf 28%), more likely to be Caucasian (73% cf 44%), with lower rates of STIs (4.7% vs 16%). 16–24-year-old Caucasian females accounted for 17.5% (N=94) of the home-testing group.
Discussion Home STI testing kits are popular with 536 distributed with 10days. Patients requesting kits were more likely to be asymptomatic, younger, Caucasian and female with lower rates of STIs. Return rates may be improved by provision of a STI fact sheet and lancet change. Linkage of laboratory and clinical databases may improve governance. Low treatment rates need further investigation.

P132 AN AUDIT OF THE USE OF SUPPRESSIVE ACICLOVIR IN PATIENTS ON STABLE ART WITH SUPPRESSED HIV VIRAEMIA IN PLASMA

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Introduction BASHH guidelines state suppressive therapy for HSV in HIV+ individuals as aciclovir 400mg BD. Anecdotally some HIV+ patients report better control of genital HSV on different antiretroviral (ART) regimens. Previous studies have shown HIV protease inhibitors (PI) may induce antiviral effects against HSV. We audited our suppressive aciclovir (sACV) use in undetectable HIV patients on stable ART against BASHH standards. We noted frequency of genital HSV outbreaks in those on PI vs non-boosted ART regimens to see any signal that PIs may confer protection against HSV reactivation.
Methods Patients were eligible if they were receiving prophylactic aciclovir, male, 18–50 years of age, with HIV viral load below 50 copies/ml on current ART. The dose of aciclovir was recorded. We also collected information on: HSV outbreaks 1/10/16-31/1/17, ART regime, CD4 count, age/ethnicity, and duration of HIV infection.
Results 60 patients were identified. 47/60 patients were taking aciclovir 400mg BD. 13/60 were prescribed ACV 400mg OD only. For those on BD:

Abstract P132 Table 1 HSV suppression by ART

	Outbreak	No outbreak
PI/boosted	1	11
Non boosted	6	29

This gave a relative risk of HSV outbreak on a PI of 0.49 over the time studied.
Discussion Of eligible patients 78.3% of prescriptions met BASHH standards. Patients on sACV dosed at 400mg BD had a lower risk (RR 0.49) of symptomatic HSV recurrence if they were on PI based ART. This is important in the

therapeutic management of co-infected patients and warrants further studies to better define the relationship.

P133 USING A CROSS SECTIONAL SURVEY TO ESTABLISH A NATIONAL PICTURE OF THE ACTIVITY, GOVERNANCE AND DELIVERY OF CONDOM DISTRIBUTION SCHEMES IN ENGLAND, IN THE FINANCIAL YEAR 2015/16

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Introduction Condoms remain a key intervention to prevent sexually transmitted infections (STI), pregnancy and HIV. C-Card is a type of condom distribution scheme (CDS) with condom demonstration and risk assessment at registration, after which free condoms are available to young people, in accessible locations.
Aim Review delivery and C-Card activity in England and its regions in financial year 2015/16, to inform policy, best practice, future monitoring and evaluation.
Methods An online survey was disseminated to sexual health commissioners of 152 upper tier local authorities (UTLA) in England between 17/12/2016 and 10/02/2017. Questionnaire domains collated information on service delivery structure, governance, user information, spend, product availability and provision, and other CDS.
Results 64% (98/152) of UTLAs completed the survey. 20 had both C-Card schemes and CDS, 57 had C-Card schemes, 14 had CDS and 7 had neither. 60 reported 4,560 C-Card outlets. The three most common settings for C-Card schemes were pharmacies (1,363, 30%), youth organisation and educational settings (1,105, 24%) and general practice (996, 22%). In 2015/16, 77 UTLAs reported 65,762 new C-Card user registrations, of which 70% were repeat users. Of 70 reporting product availability, 60 (86%) distributed condoms and lubricants. 28 distributed 896,221 products, of which 85.8% were condoms, 13.7% were lubricants and 0.5% other. Estimated spend on condom schemes were £1,491,937.
Discussion Availability of CDS in most UTLAs and high repeated use of C-Card schemes suggest acceptability and popularity. Improved evaluation of C-Card schemes for STI, pregnancy and HIV prevention is needed to demonstrate their value.

P134 PATIENT GROUP DIRECTIONS USE IN SEXUAL HEALTH

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10.1136/sextrans-2017-053232.178

Introduction Patient Group Directions (PGDs) provide a legal framework for nurses (and other health professionals) to supply/administer medication without a prescription to facilitate speedy access to medications by patients. An audit was carried out to assess local compliance and use of PGDs (anti-infective and contraception) used with in a sexual health clinic.
Methods Using Trust wide auditable criteria for PGDs, over a 6-month period (July to December 2016) 715/721 notes were audited. In particular documentation relating to administration/supply of medication and whether the PGD was used in accordance to PGD policy. These data were compared with a pervious audit (January to June 2016) where 306 notes were audited, which identified that 96% were used and documented correctly in line with policy.
Results In the audited notes (n=715) There had been an improvement with 99% of medications were issued/supplied and documented correctly in line with the PGD policy, compared with 96% in the previous audit. Those notes where practice did not meet the required standard related to documentation issues (lack of signature or indicating issued/supplied under PGD). All care provided met the eligibility requirements of the PGD.
Discussion This audit highlights importance of auditing PGD use and having a system that records errors, to help improve patient safety and staff development. Additionally, this audit demonstrates that PGDs can be safely and effectively used within the sexual health setting. Comparison of the audits demonstrates increased PGD's use, attributed to improved training and staff support.

P135 A REVIEW OF LOCAL TEST OF CURE (TOC) PRACTICE FOLLOWING TREATMENT FOR RECTAL CHLAMYDIA AND LYMPHOGRANULOMA VENEREUM

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Introduction Previous reports of up to 22% treatment failure in rectal Chlamydia informed our local clinic policy of routine test of cure (TOC) following rectal chlamydia or lymphogranuloma venereum (LGV) treatment. We set out to review our local TOC practice and treatment failure rates for both chlamydia and LGV.
Methods Case notes of patients diagnosed with rectal chlamydia and LGV between 01/07/15 and 01/07/16 were reviewed. Data was collected on symptoms, antibiotic choice, compliance and TOC.
Results There were 89 patients identified with rectal chlamydia; 7 (8%) were confirmed LGV. Median age was 30 years; 69 (78%) men who have sex with men (MSM) and 20 (22%) female. Treatment was primarily with 1 week of doxycycline (81/89; 91%).

Of 89 patients, 53 (60%) attended for a TOC with the remainder (36; 40%) lost to follow-up. There were 3/48 (6%) positive TOC results in those with non-LGV rectal chlamydia with one reporting sexual contact during treatment giving a failure rate of 4% (2/48). Of those with LGV 5/7 (71%) attended for a TOC and all were negative. Of those with a negative TOC 3/45 (6%) patients reported sexual contact during treatment.
Discussion Over a 12-month period our local treatment failure rate was low at 4% for rectal chlamydia and 0% for LGV. A significant proportion of patients failed to return for TOC. These results suggest that removal of routine TOC would be locally acceptable, reduce health advisor workload and be in line with current BASHH guidance.

P136 THE EVALUATION OF A STEPPED-CARE MODEL FOR PROVIDING EFFECTIVE AND COST-EFFICIENT PSYCHOSEXUAL SERVICES WITHIN SEXUAL HEALTH

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Introduction Increasing demand for sexual problems services plus reductions in commissioning have led to a need for high quality services delivered in a low-cost model within sexual health settings. A service redesign utilised a stepped-care model included the use of group therapy interventions as a first line treatment for erectile difficulties and painful sex. These interventions continued alongside existing MDT service provision.
Methods All patients accessing the service in the first 12 months were given self-report outcome measures at key points of the intervention including quantitative and qualitative aspects of change. Results are compared between those accessing an erection difficulties group, a painful sex group and individual psychosexual therapy sessions.
Results

Abstract P136 Table 1 Psychosexual intervention results

Intervention	Individual (n=32)	Erection Group (n=23)	Pain Group (n=9)
% significant change	50%	30%	22%
% change	38%	70%	67%
% reporting no change	12%	0%	0%

Discussion Further efforts to utilise group interventions for sexual problems may support the continued provision of psychosexual services in sexual health settings. Groups were evaluated favourably by service users and demonstrated considerable change. Qualitative feedback suggested distinct benefits of a group intervention over individual care. Those receiving a higher stepped intervention (individual sessions) may have been more complex and for others change in the problem in a traditional sense may not have been possible, however change was reported in other ways (i.e. affect in relation to the problem, relationship satisfaction).

P137 BURDEN OF CHRONIC LIVER DISEASE IN AN HIV COHORT

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10.1136/sextrans-2017-053232.181

Introduction HIV monitoring guidelines recommend 3-to-12 monthly monitoring of LFTs in HIV-infected patients. Liver-related deaths account for 10–15% of mortality in patients with HIV-infection. Draft NICE guidance, covering the identification of chronic liver disease, is under consultation.
Methods 200 HIV-infected patients were randomly selected from a cohort of 1000 patients. Those patients who were not engaged in care (i.e. less than 2 out-patient appointments in the past 12 months) or not on ARVs were excluded. Demographics, lifestyle factors and laboratory parameters were recorded. Patients at greatest risk of liver cirrhosis were screened using transient elastography.
Results Of the 161 HIV-infected patients on ARVs, 49 (30%) had a raised AST or ALT within the preceding year. Only 105 (65%) had a documented alcohol history. Of patients with elevated transaminases, the cause was already established in 21/49 (43%). Factors included alcohol, IM testosterone, viral hepatitis, cryptosporidium infection and hepatotoxic medication. 12 patients were found to have an AST-to-platelet ratio index (APRI) of greater than 0.7. Of these the causes identified included: 4 hepatitis C co-infected, 1 hepatitis B co-infected, 2 alcohol related, 1 Budd Chiari awaiting liver transplant, 2 medication related and 2 not established. Patients with raised transaminases were offered metabolic risk factors screening and transient elastography.
Discussion There is a small but significant burden of liver disease in patients on ARVs. Lifestyle counselling, to reduce harmful alcohol consumption and viral hepatitis infection could be improved. Implementation of NICE guidelines may improve the diagnosis of cirrhosis.

P138 CAN WE REDUCE TIME TO TREATMENT BY NAMING THE INFECTION IN A RESULTS TEXT?

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10.1136/sextrans-2017-053232.182

Introduction Previously patients testing positive for infections received a text (SMS) asking them to contact clinic. Often this led to missed calls, anxiety and delays in both communicating results and treatment. In June 2016 the wording of the text was changed to include the name of the infection and advice regarding how to access treatment.
Methods We identified all patients attending our service with chlamydia or gonorrhoea infection between April and December 2016. We excluded those who had received treatment prior to confirmation of their test result (e.g. symptomatic, contacts of infection) and those who did not receive a results text. We reviewed the records of 200 consecutive patients (100 before and 100 after introduction of the new text) and compared time to treatment in the two groups.
Results
Old text recipients median time to treatment was 2 days (d)/mean 3.3 (range 0–24d). New text recipients: median time to treatment was 2d/mean 3.9d (range 0–26d).
Discussion Naming the infection in texts has not led to a reduction in the time to treatment but the median time to treatment in both groups was short. Our health advisor team report anecdotal benefits following the new text including less time spent answering telephone calls therefore allowing more time for patient contact, beneficial since depletion of the health advising workforce. Additionally patients have been happy to agree to the text change in advance with a reported reduction in anxiety knowing the name of the infection.

P139 SEXUAL RISK PROFILES, AND STI TESTING BEHAVIOUR AMONG USERS OF A POSTAL HOME SAMPLING STI TESTING SERVICE (PHSSTS)

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Introduction The London Sexual Health Transformation Programme promises an online Postal Home sampling STI testing services (PHSSTS) for asymptomatic patients. Our aims were to pilot a PHSSTS, determine the STI prevalence, sexual risk profiles and STI testing behaviours.

Methods November 2015 – October 2016, adult patients visiting our clinic website had the opportunity to complete an online sexual health questionnaire and order a home sampling kit (HSK). Tests; Gonorrhoea, Chlamydia, Syphilis and HIV. Results were sent via SMS plus recommendations about their sexual health.

Results 946 HSK were ordered by 871 users. 650 (69%) samples were returned. Mean age 30 years; 58% female; 62% white British; 73% heterosexual: 20% MSM. 8% reused PHSSTS. 34% and 23% of users had never tested for STIs and HIV respectively. Median of 2 partners (<3 months).

43% reported condomless sex (<2 weeks) and 62% of MSM reported high risk behaviour. 29% women were not using contraception at all or correctly.

25%, 3% and 8% of all patients were eligible for Hepatitis B/C testing and Hepatitis vaccination respectively. 38% of eligible patients required Hepatitis B vaccination.

STI prevalence was 3%; *1 HIV, 5 syphilis, 14 chlamydia and 1 gonorrhoea*. All were recalled for treatment. Median return time for samples was 6 days.

Discussion PHSSTS proved acceptable, enhanced access and was a preferred method of testing. Additional sexual health needs could not be directly met by an online service. PHSSTS therefore must work collaboratively with GUM clinics to meet the full needs of PHSSTS users.

P140 A NEED TO REINFORCE THE IMPORTANCE OF PREGNANCY TESTING AND CORRECT ANTIBIOTIC REGIMEN: A RE-AUDIT OF PID MANAGEMENT AGAINST BASHH GUIDELINES

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Introduction BASHH guidelines (2011) for the management of pelvic inflammatory disease (PID) recommend one of two antibiotic regimens for outpatient treatment. In addition, patients should be offered a pregnancy test and full screening for sexually transmitted infections (STI).

Aim(s)/objectives To review PID management across the sexual health clinics, comparing it to the previous year's audit and BASHH guidelines.

Methods Data was retrospectively collected from December 2015 until March 2016. Data collected included whether pregnancy was excluded, STI screening, antibiotic regimen used, provision of written information, partner notification, and outcome at any follow up.

Results 51 patients were identified, 2 were excluded due to treatment by their GP. 100% of cases had at least one sign or symptom suggestive of PID. 47/49 (96%) of cases had STI screening; 41/49 (84%) had a HIV screen as part of this. Pregnancy was excluded in 22/49 (45%) of cases. A BASHH recommended antibiotic regimen was used in 28/49 (57%) of cases. Of the 21 of non-compliant cases, only 4/21 had a documented allergy or intolerance that precluded standard treatment.

Discussion Since the last audit, recommended antibiotic treatment for PID has improved, but remains low at 57%. Pregnancy exclusion was low at 45%, compared with 70% at the last audit. Differences in how healthcare professionals record information on the electronic system could partially account for this. Actions have been taken to improve treatment and pregnancy testing by giving individual feedback to the clinicians, with a re-audit planned to assess the outcome of these interventions.

P141 MANAGEMENT OF SEXUAL ASSAULT IN A NURSE-DELIVERED SEXUAL HEALTH SERVICE

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Introduction Comparing April 2014 to March 2015 with the same period in 2013–14, has seen an increase of 32% in the number of serious sexual offences reported to Police in our county.

We audited management of complainants of sexual assault attending our nurse-delivered sexual health service against BASHH auditable outcome measures (guidelines 2011) and other factors relevant to improving the quality of sexual assault aftercare offered.

Methods Retrospective study November 2014 to November 2015.

50 case notes were identified from two sites within our service – 23 from Site1 and 27 Site2. In addition to BASHH auditable outcomes, we included data such as: Time from assault to attendance, History of previous assault, Disclosure at time of attendance, Police report at attendance & Attitude to reporting at end of consultation, documentation of follow up plan re medical and psychosocial support/referrals.

Results 33/50 (66%) complainants were <25 years. Nearly 40% attended within the first 7 days, half of these within 3 days, 35/50 (70%) within 6 weeks of assault. Compliance with BASHH outcomes reached 100% in baseline STI screening and documentation of child protection needs, 84-92% for essential history components, 90% Hepatitis B offer, 79% Emergency contraception, 74% FME and 70% PEP offer. Self-harm assessment 76%. Documentation of physical injury 20% and offer of prophylactic antibiotics 2%.

Discussion We have re-designed our proforma to more readily capture poorly documented information. A review use of skill mix, training updates regarding forensic time scales/pathways for early intervention were undertaken, with algorithms included in updated proforma.

P142 RECREATIONAL DRUG USE IN HETEROSEXUAL MEN IN A SEXUAL HEALTH CLINIC IN EAST LONDON: THE FORGOTTEN MAJORITY?

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Introduction Recreational drug use is widely reported in the MSM population, however its use in the male heterosexual population is less well-described. We undertook a short survey to determine the prevalence of chemsex use in all men.

Methods Self-directed questionnaires were given to all male attendees at a GUM clinic for three weeks in December 2016. Data on demographics, level of education, sexual risk and drug use (including 'chemsex' drugs and other recreational drugs).

Results 268 questionnaires were returned. 70% (182/260) were heterosexual and 63% (155/246) were of white ethnicity. 41% of both the heterosexual and MSM groups had ever tried one drug. Prevalence of recent use (less than 1 year) was 27% (40/149) in heterosexuals and 35% (24/68) in MSM. There was much less use of 'chemsex' drugs in heterosexuals versus MSM (20% versus 9%, p=0.03). Use of crystal methamphetamine and GHB were much lower in the heterosexual population. The highest prevalence of any previous drug use was found in white men vs non-white men (73/133 (55%) versus 11/65 (17%), p <0.05) a pattern was seen in both heterosexual and MSM groups.

Discussion There were surprisingly high levels of recreational drug use in heterosexual men, especially those of white ethnicity. 'Chemsex' drugs still seem to be much more common among MSM, especially crystal methamphetamine and GHB, but the difference in mephedrone use is much less marked. These data highlight the necessity of asking all patients that attend GUM clinics about their drug use, and not only MSM.

Abstract P142 Table 1 Recreational drug use in Heterosexual and MSM.

	Ever Used			
	MSM n (%)		Heterosexual men n (%)	
All	29/70	(41)	59/144	(41)
Cocaine	21/66	(32)	47/139	(34)
MDMA	23/67	(34)	42/134	(31)
GHB	11/65	(17)	3/131	(2)
Ketamine	9/63	(14)	15/130	(12)
Mephedrone	9/65	(14)	11/131	(8)
Crystal methamphetamine	5/64	(8)	2/130	(2)
Legal	1/61	(2)	9/128	(7)
Steroids	0	-	3/130	(2)
Other	4/62	(6)	12/124	(10)

P143 ESTABLISHING A REGIONAL MANAGEMENT PATHWAY FOR PERI-ANAL AND ANAL CANCERS AND PRE-CANCERS IN A MODERATE PREVALENCE HIV SETTING

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Introduction There is a rising incidence of anal cancer and pre-cancer among people living with HIV (PLWH), largely thought to be driven by sexual transmission of the Human Papilloma virus. However, a wide difference in screening methods exists. BHIVA guidelines state centres should incorporate a pathway of managing suspected peri-anal and anal cancers and pre-cancers.

Methods Our aim was to collate data on current screening and referral methods for peri-anal and anal lesions within our region to guide establishing a regional management pathway.

An online survey was sent to specialists involved in managing PLWH. This included trainees and Consultants in Infectious Disease and Genito-urinary medicine. They were asked the methods used, if any, in routine clinics for identifying PLWH with anal and peri-anal cancers and pre-cancers, and whether there was a local established management pathway.

Results 33% of respondents stated that they regularly screened PLWH for peri-anal and anal lesions; the majority by enquiring about symptoms or carrying out proctoscopy examination, largely in men who have sex with men and PLWH with known anogenital warts. Only one Infectious Diseases specialist felt comfortable in using a proctoscope, and 67% of clinicians did not feel that they could be involved in the annual surveillance of peri-anal and anal intra-epithelial neoplasia.

Discussion The results have supported the need for the implementation of a peri-anal and anal cancer and pre-cancer management pathway within our HIV regional network, alongside further education and streamlining of screening within the region.

P144 OPTIMISING CHLAMYDIA SCREENING – A CITY AND COUNTYWIDE APPROACH IN NOTTINGHAMSHIRE

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Introduction The Public Health Outcomes Framework detection rate indicator (DRI) sets a target of ≥2,300 chlamydia diagnoses per 100,000 15 to 24 year-olds. The 2014 DRI in Nottingham City and Nottinghamshire County was 2,807 and 1,900, respectively.

We used the National Chlamydia Screening Programme's Chlamydia Care Pathway (CCP) approach to review 2014 data and identify opportunities to improve the quality of screening and increase the DRI.

Methods Routine surveillance data from GUMCAD and CTAD was used to populate the CCP for the region. Findings were discussed at the local strategic sexual health group and actions agreed.

Results Issues identified were around unknown test offer-rate, low coverage in some districts and low retesting rates following treatment. In response: existing GUMCAD codes were used to infer the offer of a test; health promotion activities focused on raising awareness of testing among key populations, primary care and providers of other young person services; re-testing pathways were audited and a text reminder system for re-screening at 3months was implemented in one of the units.

Discussion The CCP provided a strategic focus to increase understanding of screening at all stages of the pathway. It confirmed the need for an integrated screening approach across sexual health providers, primary care and broader health services who engage with young people. There was potential to achieve 'quick wins' by using the CCP to focus on each specific stage of the programme. 2017 data will be reviewed using the CCP to evaluate the impact of the plans which have been implemented.

P145 LONDON SEXUAL HEALTH TRANSFORMATION PROGRAMME

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Introduction The London Sexual Health Transformation Programme (LSHTP) is a partnership of 32 London Boroughs working to deliver a new collaborative commissioning model for open access sexual health services. The programme has facilitated cross London joint working to set up new services, agree new pricing mechanisms and ensure coordinated expert clinical specifications for all services, producing better outcomes for patients and better value for commissioners.
Methods To deliver this transformation the programme set up three distinct work streams: developing a new pan London e-services model for sexual health to better signpost patients to the right services and provide home testing kits where clinically justified; developing a new pricing mechanism that supports flexibility and planning; and supporting sub regional groups to re commission face to face services with a new agreed clinical specification to support overall system transformation objectives.
Results Transformed services; a new online offering, and a new London wide clinically agreed service specification. Improved resident access and experience. Patients will no longer need to attend a clinic if they don't wish to but will access expert advice, triage and testing in their home or safe space elsewhere. Saved approximately £30 – 40m through collaborative commissioning and patient channel shift away from expensive clinic attendance where it is not needed Built and maintained partnerships across London. It has been a major achievement to construct and sustain a collaborative of 32 London boroughs involved in this programme.
Discussion Is collaboration the way forward for effective commissioning?

P146 HAS THE ACCURACY OF SHHAPT CODING IMPROVED?

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10.1136/sextrans-2017-053232.190

Introduction An audit in 2013 suggested that only 69% of attendances and 64% of Sexual Health and HIV Activity Property Type (SHHAPT) codes were correctly assigned. SHHAPT coding supports the monitoring and reporting of STIs, facilitating robust assessment of service needs, enabling informed planning and better allocation of limited resources at all levels to reduce the level of Sexually Transmitted Infections (STIs). To achieve this coding requires accuracy and consistency and so the audit was repeated in 2016 to assess whether SHHAPT coding in this region had improved.
Methods Six new clinical scenarios were circulated to clinics in one UK region requesting that up to five individuals that regularly participate in completing the SHHAPT code assign an appointment type and the relevant SHHAPT code to each of them. The same scenarios were sent to Public Health England (PHE) and completed to provide the standard.
Results The percentage of correctly assigned attendances is 86% and SHHAPT codes are 75%, respectively.
Discussion Comparing the results from 2016 to 2013, recording of attendance type has improved to 86%, up by 17% and coding of the clinical scenarios to 78%, up by 14%.

Since 2013 new guidance and codes have been issued by PHE. To continue this improvement we suggest that at each regional meeting any new changes in the SHHAPT coding is highlighted and ask those clinicians attending to circulate to those within their department in a way that they belive to be most effective.

P147 AN AUDIT INTO THE OPTIMUM TIME FOR NEISSERIA GONORRHOEAE TEST OF CURE FOLLOWING TREATMENT IN SEXUAL HEALTH CENTRES

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10.1136/sextrans-2017-053232.191

Introduction *Neisseria gonorrhoeae* is the second most common bacterial sexually transmitted infection worldwide and has evolved resistance to several antibiotic classes. BASHH Guidelines 2011 currently recommend ceftriaxone 500mg IM plus azithromycin 1g stat as first line treatment and also recommend a test of cure (TOC) at 14 days. In our centre the time period between treatment and TOC was reduced to 14 days in July 2016. Anecdotal evidence suggests that this may be producing a higher false positive rate.
Methods Clinical notes for all positive gonorrhoea tests (pharyngeal, rectal, urethral, cervical) in a 3-month period were reviewed. Positive TOC were identified and reasons for these assessed (reinfection, treatment failure, false positive). Cycle threshold (CT) values were used to help identify false positives.
Results 7.5% of TOC results performed at 14 days were likely false positive (no risk of reinfection or treatment failure, high CT values), compared with 2.7% of TOC performed after 14 days. 8.3% of pharyngeal samples and 12.5% of urinary samples were false positive. There were no false positives found for rectal and vulvovaginal samples.
Discussion There is a significantly higher rate of false positives when a TOC is performed at 14 days and they are more prevalent in pharyngeal and urinary samples. This has a negative impact on both patient and health care provider time and can lead to unnecessary retreatment. Potential interventions could be to extend the TOC time period, include CT values for all TOC results or move to a less sensitive NAAT for TOC.

P148 FEMALE GENITAL MUTILATION – WHEN DO YOU CALL 101?

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10.1136/sextrans-2017-053232.192

Introduction Reporting cases of FGM in those aged under 18 years became mandatory in 2015. Protecting those who have been affected and safeguarding those at potential risk is paramount.
Aims To evaluate staff knowledge of FGM and the volume of FGM seen in two neighbouring sexual health services.
Methods Clinicians were asked to complete a questionnaire assessing their knowledge and understanding of the FGM care pathway. Case notes of women with a FGM code since its introduction in 2014 were reviewed.
Results
Forty-six clinicians completed the questionnaire Twenty-two women, aged 24–59 years, were identified with a FGM code, 91% were of Black African ethnicity.

Abstract P048 Table 1 Female Genital Mutilation

Do you understand the care pathway/ management of FGM?	Percentage	Action taken if < 18yr with FGM
No	13%	Unable to provide
No	22%	Appropriate action described
Yes	52%	Appropriate action described
Yes	13%	Limited understanding of required action

Overall, 74% of staff were aware of the need to ask about other daughters, social services referral and police contact. A quarter were unable to summarise appropriate action plans, of particular concern in this group were those who felt they understood the care pathway. Only a fifth stated that they coded genital piercings as FGM.
Discussion There is a clear knowledge gap in actions and coding required in relation to FGM. Over 80% staff recognised this and requested training. Plans are underway to deliver this and close the gap as a priority. A flow chart for quick reference has been developed and will be available at the conference.

P149 PATIENT INVOLVEMENT IN SEXUAL HEALTH SERVICE DELIVERY

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10.1136/sextrans-2017-053232.193

Introduction Sexual and reproductive health and HIV (SRHH) services face unique PPI challenges, as the anonymity and confidentiality required by service users can be a barrier to attracting patient input. PPI could improve sexual health services, through increased trust in services and the ability to tackle sexual health inequalities. However, specific practical guidance on how to address PPI in sexual health and the evidence to support it is sparse.
Methods This research aimed to begin building an evidence base for PPI in sexual health services through: 1) an audit of PPI in SRHH in the Bristol region; and 2) a parallel survey of potential users of sexual health services about their experiences of PPI. For the audit, 18 SRHH organisations from all those in the region invited complete a short online survey, representing a range of different service providers. For the online survey, 96 sexually active young people were recruited through a convenience sample.
Results Sexual Health patients are reluctant to get involved in PPI work, often because of embarrassment. PPI work was highly variable with some reliance on customer satisfaction approaches. Patients reported not being asked for feedback and wanted to know what PPI is for. Services cited under-resourcing and a lack of time as barriers to improving PPI work.
Discussion Improving the use of patient's voice in sexual health needs through clarity of purpose (measured against outcomes), better communication with patients, and the exploration of flexible methods that respect patients' needs for anonymity. Next steps will be outlined.

P150 PARTNERSHIPS BETWEEN SERVICES CAN SUPPORT SURVIVORS OF SEXUAL ABUSE, VIOLENCE AND EXPLOITATION

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10.1136/sextrans-2017-053232.194

Introduction The ASC Clinic (Abuse Survivors Clinic) offers specialised services to patients who have been affected by sexual violence. It is provided by Umbrella NHS Sexual Health Service and third sector partner RSVP (the Rape and Sexual Violence Project). The ASC offers emotional and medical support to survivors of sexual exploitation, coercion, abuse and violence. This is a review of the experience gained in the first year.
Methods A retrospective review of the electronic case notes for all patients who attended the ASC, November 2015-2106.
Results 46 female, 8 male, 1 transgender attended with 6 <18years. The majority of patients (41) were referred by Sexual Health staff, and others were from SARC (9), RSVP (1), another hospital (1), and 1 patient self-referred. One of the patients was experiencing on-going sexual violence at the time of attendance, 18 had experienced it within the past month, 14 between 1 month and 1 year before being seen, and 22 more than 1 year previously. Nearly all (5) of the under 18-year olds were referred to Safeguarding teams, and 9 of the adults. The majority accepted services from both partner agencies. 128 appointments were made with 63 attendances (DNA rate 49%).
Discussion We are increasingly aware of the numbers of people who have experienced sexual violence. The ASC provides a dedicated service for this vulnerable group. The innovative approach of working with the third sector helps combine experience and expertise enabling more holistic care. Further work is needed to improve clinic accessibility and to evaluate patient experience.

P151 DEVELOPING AN ASYMPTOMATIC SCREENING PATHWAY FOR MEN WHO HAVE SEX WITH MEN

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10.1136/sextrans-2017-053232.195

Introduction Many sexually transmitted infections (STIs) are known to disproportionately affect men who have sex with men (MSM) in the UK; therefore regular easily accessible asymptomatic screening is vital among this group. Asymptomatic screening pathways that allow healthcare support workers (HSCWs) to see patients can reduce long clinic waits, which may encourage more people to attend for screening and increase capacity for screening.
Methods We developed and trialled an asymptomatic pathway for MSM within our service. This extended our existing pathway, which allowed asymptomatic service users to complete a questionnaire and see a HCSW, to include MSM, as it previously had not. The service was piloted, then implemented and audited.
Results A 5 month audit of 45 notes showed that the pathway is generally being used appropriately. 93% (27/29) service users were offered referral to a health advisor when indicated by the pathway and two were offered referral without any clear indication. This resulted in 29(64%) men seeing a health advisor for health promotion after completing their STI screen as 2 men declined. All patients received appropriate Chlamydia, Gonorrhoea, HIV, Syphilis and Hepatitis B testing, but 7 (16%) were not tested for Hepatitis C when indicated by the pathway. 4(9%) men had an STI (Chlamydia or Gonnorhoea).
Discussion We believe this model can reduce clinic visit duration. This should increase accessibility and acceptability and also allow trained staff to manage more complex patients, while allowing for risk identification and health promotion among asymptomatic MSM who may also be at higher risk.

P152 STAFF SATISFACTION IMPROVEMENT WORK: ACTIVELY ASKING, LISTENING AND RESPONDING TO THE CONCERNS OF OUR STAFF

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10.1136/sextrans-2017-053232.196

Introduction Contract tendering and service integration has resulted in great uncertainty for sexual health staff. Our service has recently integrated with sexual and reproductive health (SRH) and is currently under tender. We aimed to review and address the satisfaction of our staff.
Methods An online survey was disseminated to staff at our sexual health service.
Results 73% of staff responded: 13 doctors, 9 nurses, 6 technicians, 15 health advisors/psychologists, 8 receptionists, 8 administrators, 3 anonymous. On a scale of 1–10, staff rated: feeling valued 5.9; enjoying work 6.4; day-to-day support 5.7. Scores were lower among receptionists (4, 4.1, 3.6 respectively). 61% felt day-to-day issues were dealt with in a timely manner. Cascade of information from management to staff was deemed 'too little' by 53%. 34% stated they did not have the opportunity to contribute to decisions affecting them. Staff found it easier to raise concerns with their line manager (6.7/10) than with management (5.7/10). These scores were lower among receptionists (3.6/10, 4/10 respectively).
Discussion Improvement work is addressing the issues raised by our staff. Initiatives include: Staff Member of the Month Award; Daily team huddle actively including receptionists, addressing day-to-day issues; Psychology session with receptionists to better understand their concerns; Clinic has relocated to be next to reception (rather than on a different floor); A buddying system for incoming SRH staff; Regular integration emails from management and whole team briefings.
Discussion Our survey demonstrates the need to actively ask, listen and respond to staff's satisfaction, especially during such uncertain times.

P153 USING INFORMATION TECHNOLOGY TO IMPROVE LINKAGE INTO SEXUAL HEALTH CARE IN PATIENTS RECEIVING HIV POST EXPOSURE PROPHYLAXIS FOR SEXUAL EXPOSURE (PEPSE) IN EMERGENCY DEPARTMENTS

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10.1136/sextrans-2017-053232.197

Introduction HIV PEPSE should be commenced within 72 hours (ideally 24) after possible exposure to HIV. Patient education on PEPSE includes advice on attendance at Emergency Department (ED) if outside opening hours of local sexual health services (SHS). Our healthboard serves a population of 1.2 million with four EDs. An initial four month audit revealed 12 patients who received a 5-day starter pack of PEPSE at ED and no communication between departments; patients were told to self-refer to SHS. We recognised there was no robust mechanism to ensure these high risk patients were not lost to follow up (LTFU). HIV testing at baseline was also poor in this setting, highlighting importance of linkage into SHS.
Methods HIV PEPSE 5 day pack leaflets were altered to ask the dispensing clinican to refer patient via secure email or telephone message to the sexual health advisers.
Results Prospective four month re-audit revealed 19 patients attended ED for PEPSE and all subsequently attended SHS for follow up(100%). 12/19(63%) were referred by email, 6/19 (32%) via answering machine, 1/19(5%) self referred. 11/19 (60%) reported unprotected receptive anal intercourse with someone from a high risk group.
Discussion Following implementation of the email/telephone referral intervention, we found an increased number of patients received HIV PEPSE from EDs in the health board area and all were successfully linked into sexual health services. We cannot be sure that this increase is due to the prevention of patients being LTFU; other reasons include an increased awareness of PEPSE and where to obtain.

P154 HOW WELL ARE WE MANAGING LYMPHOMA IN OUR HIV COHORT OVER 5 YEARS: A REGIONAL AUDIT IN THREE MAIN HUBS

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10.1136/sextrans-2017-053232.198

Introduction Since the introduction of antiretroviral therapy, the life expectancy of HIV infected patients has increased significantly. As the incidence of opportunistic infections accounting for HIV related deaths has declined, malignancies now account for an increasing proportion of these mortalities, with lymphoma presenting second most commonly. In order to determine whether HIV positive patients with lymphoma are receiving best care, patients from three hubs within the region were reviewed.
Methods Data was collected retrospectively from HIV positive patients with lymphoma from 1st of January 2010 to 31st of December 2014.
Results Total number of patients in the study was 25 across the three centres with 8,12 and 5 patients from each centre. All patients underwent the recommended diagnostic procedures for diagnosis and 96% received appropriate imaging for staging. Of the 20 patients where documentation was available, 70% were diagnosed with stage IV lymphoma and 50% had the International Prognostic Index (IPI) score of 3 or more. 5-year survival rate was 72% and in those followed up for a minimum of 2 years the 2-year progression free survival rate was 100%. 28% patients died during the study period, 43% of whom had a late diagnosis.
Discussion Management of lymphoma within three centres in the region is in line with current best practice guidelines. In order to improve the survival further, early diagnosis and treatment of HIV were identified as crucial factors necessitating increased awareness of HIV testing.

P155 EVALUATING THE EFFECTIVENESS OF GRAM STAIN MICROSCOPY IN IDENTIFYING GRAM NEGATIVE INTRACELLULAR DIPLOCOCCI SUGGESTIVE OF GONORRHOEA NEISSERIA

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10.1136/sextrans-2017-053232.199

Introduction Gram stain microscopy is an effective tool in the management of gonorrhoea in symptomatic patients, allowing for the visual identification of suspicious bacteria, which when also considering the history and risk, can be indicative of a current gonorrhoea infection allowing for rapid treatment and partner notification initiation. This is an on-going audit to verify the effectiveness of in-house diagnostics.
Methods All patients found to have a positive culture result for gonorrhoea had their notes reviewed to ascertain if presumptive gonorrhoea had been diagnosed at attendance as well as the presence of symptoms, contact status and vaginal flora grade (in women). If microscopy was undertaken but negative, the slide was also reviewed. Slides found to be positive were feedback to staff members.
Results Data from July 2016 – January 2017:
Male urethral samples 147/157 (93.6%) infections were correctly identified, when asymptomatic contacts were excluded 147/154 (95.5%) were identified, and of those not identified, 4 were negative on review.
Female cervical samples 5/20 (25%) infections were correctly identified, when asymptomatic contacts were excluded 5/19 (26.3%) were identified. Of those not diagnosed on the day, 9 were negative on review.
Discussion Microscopy identified 95.5% of symptomatic male urethral infections and 26.3% of female cervical samples. There was also a low 'failure' rate, only 7/24 slides were positive on review and therefore 'true missed' on day diagnoses. Effective on day diagnosis can prevent further transmission, allow faster access to antibiotics, allow for prompt partner notification and is a rewarding skill for the GU staff.

P156 WHAT IS TELEPHONE ACCESS REALLY LIKE FOR GUM CLINIC PATIENTS IN THE U.K.?

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10.1136/sextrans-2017-053232.200

Introduction How patients fare when accessing care by telephone at GUM clinics in the UK can be assessed by 'mystery shopping' methods. This study aimed to establish current access levels when contacting clinics by telephone and investigate the potential barriers.
Methods During October – November 2016 all 262 GUM Clinics in the UK were called during clinic opening times on eight occasions, each by male and female researchers posing as patients requesting to be seen as soon possible.
Results Overall 1589/1905 (83.4%) calls were offered an appointment. Of these, 63.7% of 'patients' were invited to attend a walk-in service. Most clinics were consistently contactable, with 72.9% of calls being answered on the first attempt, however 22.9% of clinics were un-contactable at on at least one occasion. Contacting a clinic over four calls can establish the probability of clinic access, with 68.8% of clinics accommodating a minimum of 6/8 callers.

The time to speak to a human ranged from 1 second – 39 minutes. The mean length of conversation was 93 seconds, with longer speaking time increasing chance of success. Although male and symptomatic 'patients' spent longer on the phone, females were 14.6% more likely to offered an appointment ($p=0.037$). Symptomatic scenarios did not have improved access over asymptomatic contacts ($p=0.074$).
Discussion Access appears to be falling further below the BASHH standard. Various difficulties in establishing contact were identified, including long hold times and the need for multiple call attempts, that may be barriers to patient access.

P157 UTILITY OF CHLAMYDIA CARE PATHWAY FOR STANDARDISATION OF QUALITY MEASURES FOR MANAGEMENT OF CHLAMYDIA TRACHOMATIS

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10.1136/sextrans-2017-053232.201

Introduction The Chlamydia Care Pathway (CCP) describes individual steps of comprehensive case management for

Chlamydia trachomatis (CT) providing standardised methodology to compare outcomes. We audited CCP in a central London service to identify aspects requiring service improvement.
Methods All patients diagnosed with CT in 6 months in 2016 were identified from the electronic patient record system. A random sample of 60 notes was assessed against each step of the CCP.
Results There were 35,995 new patient appointments and 1700 patients had positive CT results. Of the sample, 32 were male, 28 female. Median age for men was 34, range 20–71 years, women 24, range 17–28 years. 14/32 of males were MSM, 18/32 heterosexual. All females were heterosexual. 14/60 of patients were contacts of CT and 11 of the male patients were diagnosed with non-specific urethritis and were treated on the same day. Test turnover time was median 6, range 2–10 days. 50/60 patients were informed on the day the results were available. Of the 35/60 patients requiring treatment, time taken for them to attend was median 1, range 0–50 days. 56/60 had documented contacts informed, 18/60 had documented contacts treated. 19/60 attended for repeat tests 3 months later of whom 2 had new infections.
Discussion This review identified areas for improvement, such as partner notification documentation and test turnover time. Review of other sites within the sustainability and transformation footprint is planned. This tool may be useful to commissioners for standardising quality measures and comparing performance of testing sites in a locality.

P158 BENEFITS OF DISINTEGRATION OF A HIV SERVICE FROM A SEXUAL HEALTH SERVICE?

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10.1136/sextrans-2017-053232.202

Introduction With an imminent split of our HIV service from an integrated sexual health service we felt it a timely opportunity to address anonymised blood testing in the HIV service.

Historically patients have had routine monitoring for HIV under their GUM number unless pregnant or have requested specific bloods under their name. Continued isolation of the HIV service, while complying with HIV patients wish for enhanced confidentiality, can have a negative impact on their care- increasing clinical risk and duplication of tests. As our patient age they require multidisciplinary input to manage comorbidities so integrated working is essential.
Methods Patients were provided with an information leaflet about the service change and completed a survey/consent form starting in December 2015. If patients agreed to the switch this was implemented for their subsequent bloods.
Results Our cohort size in 2015 was 394 – 2/3rd are male and over half MSM. So far 301 patient questionnaires have been analysed.

Results show 93% of patients have consented to changing to named bloods with a generally positive feedback to this change. We will present the results looking at the differences between those that consent and those that do not.
Discussion Results suggest that the majority of patients are not concerned about loss of anonymity through switching to named blood samples. Switching to named blood samples is one small step in reducing the isolation of HIV care.

P159 AUDITS OF BOTH MANAGEMENT OF CHLAMYDIA AND ALSO EMERGENCY CONTRACEPTION PROVISION AS A MARKER OF QUALITY IN AN INTEGRATED SERVICE

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10.1136/sextrans-2017-053232.203

Introduction The county wide sexual health service has been integrated long-term as regards health care worker (HCW) training and governance. Service delivery still remains in some units geared to towards either contraception (C+RHC) or sexually transmitted infections (STIs) management although all patient needs are addressed holistically. Is there equitable service delivery in all units?
Methods Audits of both chlamydia management and emergency contraception provision was carried out across all subunits regardless of subspecialisation.
Results In the chlamydia audit, standards were achieved for offering anti-chlamydial treatment (100% achieved) and partner notification verified by HCW (0.47 in STI units, 0.58 C+RHC units). Standards were suboptimal for a) the offer of written information (45% for STI units 18% for C+RHC units and b) offer of retesting for under 25s (61% for STI units, 68% for C+RHC units.) Emergency contraception audit standards were achieved in offering quick start contraception (96%) but suboptimal a) for IUCD offer (73% for STI based units, 57% for C+RHC units), b) documentation of hours since last unprotected sex (58% for STI units 89% for contraception based units), c) documentation of day of cycle (69% for STI units, 89% for contraception units and d) offer of STI screens (82% in STI based units, 76% in contraception units)
Discussion Although variation between units exists it is noteworthy that partner notification was best delivered in C+RHC unit setting and IUCD offer in STI unit setting. Emphasis on documentation was made to staff with reaudit planned.

P160 TO SEE OR NOT TO SEE

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10.1136/sextrans-2017-053232.204

Introduction Determining which patients need to be seen on the day they attend. Sexual Health Services are challenging given the increasing demand for services and limited capacity. A new questionnaire based triage system was implemented in a busy, urban, Level 3 Sexual Health Service. We have reviewed the outcomes of implementing this triage process to assess how many triaged patients were seen the same day and the symptoms they reported, how many received future appointments and of those, how many returned. We also assessed the safety of a questionnaire based process for triage.
Methods Patients triaged in November 2016 were identified and their notes reviewed.
Results Of 255 recorded triages, 119 notes have been reviewed to date. Of these, 92 (77%) were seen the same day but 2 left before being seen. 27(23%) received a follow-up appointment, and 89% of these attended.

Of the 92 given a same day appointment, 36 (39%) reported pain/dysuria, 23 (25%) were contacts of an STI, 2 required PEP, 6 had discharge, 3 recurrent HSV, 2 patients had been diagnosed with Chlamydia elsewhere, 2 had non-specific symptoms, 1 requested a TOP and 1 reported sexual assault. 12 had lumps or itching, 4 were asymptomatic.

Discussion This review demonstrated that questionnaire based triage is effective and as it is quicker than face to face triage, capacity can be increased. 77% of patients were offered same day review which highlights the importance of flexibility within services to ensure patients can be seen within 48hrs when appropriate.

P161 ABSTRACT WITHDRAWN

P162 NHS GGC STAFF HIV ANTI-STIGMA CAMPAIGN

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10.1136/sextrans-2017-053232.205

Introduction People living with HIV, and maintained on ARVs, can live long and healthy lives.

Consequently, there is a growing cohort of people living and ageing with HIV, who are attending NHSGGC for non-HIV related conditions. However, many patients report experiencing stigma and discrimination within these services. NHSGGC responded to this by creating a HIV anti-stigma campaign.

Methods A baseline staff survey was conducted to ascertain knowledge, attitudes and training needs. These results and input from the HIV Patient Forum shaped the campaign, which consisted of: A range of materials, merchandise and activity including posters, road shows, factsheets; training, digital updates and direct messaging to service managers; A patient toolkit which empowers them to challenge stigma and discrimination; Short dramatic videos illustrating patient experience; A repeat staff survey was carried out in 2016

Results 4000 responses to the baseline survey; 9,325 unique website hits; 300+ staff engaged at road shows; 15 delegates attending training; 1,521 responses to the repeat survey; excellent partnership working between NHSGGC staff and members of the patient forum.

Discussion The campaign was successful in raising HIV with non-specialist staff. However, uptake of training was low despite an expressed need. Lack of time to train in non-mandatory areas was an issue. Those that did attend training evaluated it well. Results from the repeat survey will shape future interventions for staff.

P163 HAART PRESCRIBING AND BHIVA STANDARDS OF CARE FOR PEOPLE LIVING WITH HIV AUDIT

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10.1136/sextrans-2017-053232.206

Introduction We audited our service against the BHIVA 2013 Standards of Care for People Living with HIV, BHIVA treatment guidelines for HIV-1-positive adults 2015 and North West 2015 treatment algorithm for HIV-1-positive adults 2015.

Methods This is a retrospective audit involving the review of all patient notes (84). 64 patients were excluded as they were started on medication before 2013.

Results 40% of all patients had a CD4 count of more than 350 when they were started on medication and 10% had a CD4 count of <200. Only 5% had HIV related symptoms. 15% were started as prevention of transmission.

30% (6 in 20) of patients were started on treatment on/after 2015. Only 17% (1 in 6) of these patients had been prescribed treatment according to the North West 2015 algorithm (The patient was given Kivexa based therapy when they could have had Truvada). First line therapy according to BHIVA 2015 guidance was prescribed in 100% of patients (Standard of care target >75%).

100% of patients adhered to their medication within the first 3 months (Standard of care target >95%). None of the patients who had viral loads done had experienced virological rebound (Standard of care target <2%).

Discussion We are 100% compliant to the BHIVA treatment guidelines while only 17% compliant to the North West algorithm. To improve our service and make it more viable, we will update our proforma according to the North West algorithm, which reflects the availability of cheaper generic drugs and NHS England guidance.

P164 AUDIT OF THE MANAGEMENT OF GENITAL HERPES INFECTION IN COLCHESTER SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.207

Introduction Genital Herpes infection, caused by Herpes simplex virus is one of the common sexually transmitted infections in the UK. According to Public Health England STI report (2015) the percentage increase of newly diagnosed Herpes infection from 2006 to 2015 is 67%. BASHH published new Herpes management guidelines in 2014. We evaluated the management of Herpes infection at our clinic against these guidelines using electronic patient records over a six month period in 2015.

Methods Retrospective case notes review of all patients diagnosed with genital herpes infection (coded C10A) from July to December 2015. Individual case records were scrutinised and evaluated against auditable outcome measures outlined in BASHH 2014 guidelines.

Results There were 102 newly diagnosed Cases of HSV in this 6 month period. All patients had HSV detection by PCR confirmation and 100% had at least one detected HSV typed. Recommended antiviral therapy offered to 95% of the patients who presented within 5 days of onset of symptoms (target 97%). The percentage of patients who were given verbal and written information about HSV was 54%.

Discussion Our audit shows we met the BASHH standards by virologically confirming and typing all diagnoses of genital herpes infection. We failed to meet the standards on patient education and documentation. Since April 2016, our service has switched to new electronic patients records which has a dedicated section on patient education This will help improve our performance. This will be re audited next year.

P165 HIV INPATIENT EXPERIENCE

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10.1136/sextrans-2017-053232.208

Introduction 'Standards of care for people living with HIV 2013' provides recommendations for the clinical care of HIV positive patients, including inpatients. We conducted an audit to describe patterns of service use with particular reference to time to diagnosis of HIV, presenting illness, medication, length of stay and follow up.
Methods Data was collected retrospectively from notes of 36 inpatients from 1st January to 31st December 2014.
Results 4 patients were newly diagnosed with HIV, of which, 3(75%) presented with an AIDS defining illness. HIV test was performed in MAU on 2 patients (50%). In the remaining 32 patients, 8 presented with AIDS defining illness. 11% had evidence of drug-drug interactions. 37% had no evidence of HIV Team inpatient review. 25 patients were discharged within 7 days, however, 4 stayed for more than 28 days. Only 41% were seen in HIV Outpatients within 4 weeks after discharge. After admission with AIDS defining diagnosis, all patients were alive at 30 days and 72% alive at 6 months.
Discussion Complex care accounted for a sizeable proportion of our inpatient work. Current BHIVA recommendation of immediate commencement of HAART will significantly reduce disease progression and inpatient admission. This audit highlights the need for continued effort to raise awareness of HIV testing among non-HIV specialists and GP's.

P166 PARTNER NOTIFICATION: ARE AUSTRALIAN APPROACHES FEASIBLE FOR THE CHILEAN CONTEXT?

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10.1136/sextrans-2017-053232.209

Introduction Partner Notification (PN) in Australia has been studied and improved in recent decades. International researchers have highlighted the use of new technology as an alternative approach for PN. Using the Australian experience as an example, we aim to explore clinicians' perspectives about the use of specialised websites, such as 'Let them know' and professional counselling support, to facilitate PN in the Chilean context.
Methods 58 semi-structured interviews were conducted with health care providers (HCP) and key informants. A third of the interviews were transcribed verbatim and translated from Spanish to English for thematic analysis, which followed an inductive approach based on grounded theory. Following the identification of themes, remaining interviews were coded utilising a method of constant comparison to highlight concordance and dissonance of participant views.
Results The majority of participants were unaware of the use of new technologies for PN, and demonstrated a high interest. Many agreed this could be a feasible strategy considering the high use of mobile technologies and the Internet in Chile. Participants' primary concerns around this approach were confidentiality, privacy and efficacy, given the local cultural context. The creation of a counsellor position for professional support and guidance was identified as essential to strengthen PN in Chile.
Discussion The use of new technologies for contacting sexual partners with professional counselling support could be an alternative PN strategy for Chile. However, the involvement of local staff will be essential in tailoring interventions.

P167 PILOT FEASIBILITY TRIAL OF TARGETED SEXUAL RISK REDUCTION INTERVENTIONS WITHIN SEXUAL HEALTH SETTINGS IN ENGLAND – THE SANTÉ PROJECT

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10.1136/sextrans-2017-053232.210

Introduction There is evidence from RCTs that brief behavioural interventions can have modest but valuable impacts on sexual risk behaviours and STIs in young people and men who have sex with men (MSM). Implementing these nationally could reduce STIs, but has not yet been done. Santé aims to adapt and pilot a package of evidence-based risk reduction interventions, and assess the feasibility of conducting a large-scale effectiveness trial.
Methods Following a systematic literature review, mixed-methods evaluation of existing practice, and patient and provider preference, a process of Intervention Mapping was used to adapt effective interventions and create an intervention package for MSM and young people. Triage algorithms were developed using routine surveillance data. A pilot cluster trial is running in eight sexual health clinics. Quantitative process data and qualitative interviews with patients and providers will assess feasibility.
Results The intervention package is a triage algorithm which directs patients into a low-intensity digital intervention or high-intensity one-to-one behaviour change consultation. No identified digital interventions were available for piloting; therefore, patients are directed to suitable health promotion websites. An intervention manual incorporating a Five Step Pathway was developed for the one-to-one consultation, detailing the behaviour change elements. Preliminary pilot results will be available in June 2017.
Discussion The pilot will identify issues that need addressing to make a large trial feasible. Although intended to be deliverable within existing clinic resources, current service changes threaten the viability of such innovations. Further adaptation and development of digital resources will be needed prior to implementation.

P168 DATA ANALYSIS OF A SELF-COMPLETED QUESTIONNAIRE FOR PATIENTS WITHIN A MEN-HAVING-SEX-WITH-MEN CLINIC

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10.1136/sextrans-2017-053232.211

Introduction The questionnaire was created to discover the characteristics of the MSM population attending a clinic dedicated to their sexual health needs. It covered reasons for attendance, risk factors for sexually transmitted infections and

blood-borne viruses transmission and usage of post-exposure prophylaxis and pre-exposure prophylaxis. The data would be used for adaptation of the clinic.
Methods The questionnaire was given to clinic attendees for a 75 day period in 2016 and kept anonymous by a unique client number. The collated data was analysed and reproduced in graph and table form for categories split into reason for attendance.
Results Acceptability of the questionnaire was high at 99.2%. The data analysis showed a large asymptomatic client population (57%) attending the clinic for sexual health screening. For contacts of infection, HIV and gonorrhoea were the most prevalent. For STI and BBV infection risk factors, 15% of clients did not use condoms, while 49% of clients did not know a sexual partner's HIV status. Use of PEP was low but showed a majority using it since 2015, while there were 5 users of PrEP.
Discussion The study showed a majority low-risk MSM population using the dedicated clinic. The survey has influenced clinic redesign with the introduction of test-only clinics for the low risk cohort. However the clinic may not be seeing the high-risk patients who would benefit from senior medical input rather than just a sexual health screen. Data showing usage of PEP and PrEP has given a baseline for comparison in future studies.

P169 GONORRHOEA CULTURE AUDIT IN A COMMUNITY SETTING

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10.1136/sextrans-2017-053232.212

Introduction Gonorrhoea (GC) accounted for 10% of all STI diagnoses in 2015. Diagnoses increased by 11% from 2014 to 2015, continuing an established trend beginning in 2012. BASHH guidelines recommend that cultures are routinely taken as it is cheap and offers antimicrobial susceptibility testing which is of increasing importance given the emergence of resistant GC strains. The primary aim of this audit was to assess the rate of GC culture and the outcome of the culture results in a community service.
Methods 20 cases, coded positive for GC, were recruited over a 19 month period. The standard for GC culture rate was set at 100%, with positive GC culture set at 85–95%. Standards were established from BASHH GC management and testing guidelines.
Results Of the 20 patients 55% had a sample for GC culture taken. The sex distribution of culture sampling was 10:1, male to female. Of these 11 patients 45% had a positive culture, despite all patients having a positive NAAT. These rates are almost half of the expected standards.
Discussion Cultures for GC are not routinely taken at this service. It is plausible that the incorrect storage of samples and delay in plating are contributing factors to the increased false negative rate. This may be a nationwide effect as services move into the community and transport times to laboratories increase. The audit results have been presented to staff at the service and discussion is ongoing with the laboratory regarding expediting transport of samples.

P170 IMPROVING STAFF INTEGRATION THROUGH MEANS OF A COMBINED CLINIC ROTA

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10.1136/sextrans-2017-053232.213

Introduction With the national move to integrated sexual health services confusion regarding staff leadership and roles can increase already high levels of stress and anxiety. Costs for professional rota management services can vary so we aimed to achieve an in-house system.
Methods Though co-located in the same building SRH and GU/HIV clinics were traditionally staffed separately. The local tender was awarded to the University Hospital clinic as hub with spokes providing an equitable city-wide service. Previously there were four separate rotas to staff SRH, GUM, and HIV services. Bringing together a group of health professionals with varying degrees of dual training can be difficult so we took this opportunity to ensure an adequate skill mix was available for each clinic, help staff identify who was available for advice, improve cross-specialty training and thereby enhance the overall patient experience. A clinic co-ordinator doctor role was established to provide focus for leadership and advice (GU/HIV) with corresponding clinic co-ordinator nurse staffed by senior contraception clinicians.
Discussion Rotas were combined onto a single colour-coded template. Editing rights were restricted to named individuals aware of staff mix and availability. Numbers were calculated at the start of each day and communicated to reception to ensure spread of appointments. The CCD role was utilised to help teach SRH colleagues in GU with the CCN providing a reciprocal service for contraception. Combining the rota encouraged staff to integrate and get to know each other so that perceived fears were dealt with in a safe reassuring environment.

P171 DRUG-DRUG INTERACTIONS IN HIV PATIENTS TAKING PHARMACOKINETIC ENHANCERS

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10.1136/sextrans-2017-053232.214

Introduction Antiretroviral medications have the potential to produce serious drug interactions by interfering with the hepatic cytochrome P450 cascade. Ritonavir, a protease inhibitor, is a known CYP450 inhibitor that is commonly used in the treatment of HIV[1]. Iatrogenic Cushing's syndrome is caused by exposure to glucocorticoids and may be promoted by interaction with additional drugs that result in hypothalamic-pituitary adrenal axis suppression[2]. It is well documented in HIV patients receiving inhaled steroids in combination with a ritonavir-containing antiretroviral regimen[3]. Following one such severe drug-drug interaction in a patient, a clinical audit was conducted to identify potential drug-drug interactions in a HIV clinic at Beaumont Hospital, Dublin.
Methods 200 patients receiving Ritonavir were interviewed and screened for harmful prescribed and non-prescribed co-medications. Patients receiving regular steroid doses and

Ritonavir were identified and all drugs were cross-referenced to the Liverpool Drug Interactions website to highlight any dangerous drug interactions.
Results 86% of patients had concomitant prescribed medications, three-quarters of which were undocumented. Furthermore, 45% of patients used regular over the counter-medication and 2.7% used recreational drugs. 8% of patients were flagged for potentially dangerous drug-drug interactions and of these, 15% contained steroids.
Discussion The interaction between corticosteroids and PIs is significant and deserves close attention and evaluation. Timely communication among all prescribing physicians for a given patient is indicated in order to proactively detect significant interactions before they manifest themselves clinically.

Miscellaneous

P172 ENJOY YOURSELF, ITS LATER THAN YOU THINK!

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10.1136/sextrans-2017-053232.215

Introduction Erectile Dysfunction (ED) affects 10% of men and those affected may present at Genitourinary Medicine clinics. It may indicate significant underlying pathology and is often the first presenting symptom of cardiovascular disease (CVD) and diabetes.
Methods All new referrals to the sexual dysfunction clinic in 2006 were identified. Electronic medical records were reviewed to determine clinical outcomes 10 years after initial attendance.
Results 138 patients identified; 9 were excluded due to unavailable records. Mean age at referral was 47 years. 68% (n=88) had predominantly organic ED (mean age 52 years) while 32% (n=41) were diagnosed with an underlying psychological cause (mean age 37). Of those with an organic cause, 20% (n=18) had known CVD and 17% (n=15) had diabetes. By 2016, 10% (n=13) of all patients had died. Of those alive, 30% (n=35) remained on treatment for ED. In the intervening years, a further 10 patients were diagnosed with CVD, 9 diabetes, 3 peripheral vascular disease, 3 Parkinson's disease and 2 with stroke. Of those initially referred with ED, after 10 years, 41% had proven CVD, 27% were diabetic and 10% developed other associated conditions.
Discussion 10-year outcomes for patients presenting with ED are associated with significant levels of morbidity and mortality. The incidence of underlying vascular disease and chronic conditions in this cohort of patients is significant. Recognition of ED is important in GUM settings to enable early detection of significant underlying co-morbidities.

P173 ARTISTIC REPRESENTATIONS OF HIV IN NORTHERN IRELAND: HOW THE ARTS CAN CONTRIBUTE TO HIV AWARENESS, PREVENTION AND STIGMA-REDUCTION IN A CONSERVATIVE ENVIRONMENT

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10.1136/sextrans-2017-053232.216

Introduction The International AIDS conference in Melbourne in 2014 gave rise to a diverse set of cultural responses around HIV and AIDS, including my own practice-as-research performance installation, *GL RY*, in a public square throughout the conference. Using the concept of a hole as metaphor for transmission and transformation, it asked what histories, secrets, stigma, information, art, affects might slip through a small hole?
Methods In 2016 the work had a new iteration in Belfast for the Outburst Queer Arts Festival. We worked closely with people living with HIV in Northern Ireland to find ways to convey their experiences safely in a public arena. It took up the challenge from 2014 where, working alongside long-time HIV activist and artist Kim Davis, it became clear that women are particularly marginalised in the public discourses and representations of HIV and AIDS. This resulted in a performance installation in a shopfront in Belfast city centre, focusing on the experience of women and asking for solidarity with women living with HIV through participation.
Results Three new works on HIV and AIDS made in Belfast in November 2016 with collection of data including audience and participant feedback.
Discussion The paper argues that art can intercede in powerful ways in public discourses, in modes that other forms of information and education cannot. In creating a sound archive based on interviews with people living with HIV, I suggest that this work could productively be used in therapeutic use in clinics and in HIV agencies and medical training.

P174 CLINICAL OUTCOMES IN ADOLESCENTS WITH PERINATALLY ACQUIRED HIV (PAH) TRANSITIONING FROM PAEDIATRIC TO ADULT CARE IN A LARGE REGIONAL HIV CLINIC IN LONDON

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10.1136/sextrans-2017-053232.217

Introduction We assessed outcomes in PaH adolescents transitioning from paediatric to adult care within a regional HIV clinic.
Methods Retrospective case-note review 10/02/04–31/12/15. Data collected: demographics, CDC stage, viral loads (VL), CD4 counts, antiretroviral therapy (ART), resistance and loss to follow up; using a standardised database. Pre- and post-transition outcomes were compared using paired T-tests for means and McNemar's Exact tests for proportions.
Results 57 patients; 29(51%) male, 34(60%) born outside UK, 51(89%) black African. Median age at diagnosis 3 years [range 0–18]; at transition 18 years [15–20]. Median time since transition 5 years [1 month–13 years]. At transition CDC B 27/57 (47%), CDC C 18/57(32%), post transition 28/57(49%), 20/57(35%), respectively, including one suicide. Of those with $\geq$2 years data post-transition, 31/48(65%) had two consecutive VL>40c/mL or one VL>10,000c/mL in the 2 years pre-transition, compared with 22/48(46%) post-transition (p=0.035). Mean CD4 count 12 months pre/post-transition 520 c/mm^3, 500 c/mm^3, respectively (p=0.4). At transition 52/57(91%) on ART (vs. 55(96%) at last visit, p=0.1), 10/46(22%) 1st line (5/55(9%) last visit), median duration of ART 7 years [0–18]. Resistance: 18/46(39%) nil, 13/46(28%) $\geq$1, 13/46(28%) $\geq$2,

1/46(2%) ≥3 drug classes. 4 patients were lost to follow-up (LTFU), all returning within 5 years [1-5].
Discussion There was no difference in mean CD4 pre or post-transition, but the proportion who were suppressed improved post-transition. CDC stage progressed in 3 adolescents. All patients had options for suppressive ART although few were on 1st line. There was no long-term LTFU.

P175 VACUUM THERAPY IN ED: OUTCOMES FROM A SPECIALIST VACUUM CLINIC

Stephen Megarity*, Wallace Dinsmore, Laura Bell, Emma McCarty. *Royal Victoria Hospital, Belfast, UK*

10.1136/sextrans-2017-053232.218

Introduction Vacuum devices are a safe and inexpensive treatment for erectile dysfunction (ED) particularly when other treatments are not tolerated or contraindicated.
Methods Chart review of patients attending specialist vacuum clinic over 2 year period was conducted. Data collected included outcomes with previous treatments and vacuum device.
Results 55 patients (median age of 65 years) were prescribed a vacuum device. The median time from initial assessment at ED clinic to prescription of the device was 18 months. The majority had significant underlying co-morbidities: 25/55 diabetes, 23/55 CVD, 3/55 prostate surgery, 2/55 stroke, 1/55 spinal injury and 1/55 MS. All patients received prior ED treatment with PDE5i inhibitor and/or intracavernosal alprostadil. With regards to PDE5i, 43/55 reported poor/no response, 1/55 failed to tolerate, and in 11 patients a PDE5i was contraindicated. All 55 patients were subsequently offered intracavernosal alprostadil injections however 17 declined. Of the 38 patients who accepted, 27 reported poor/no response, 7 discontinued due to pain and 4 enquired about alternative treatments. On initial assessment at specialist vacuum clinic 32 patients consented to physical demonstration and all achieved an erection suitable for penetration. 36/55 were discharged after their initial vacuum assessment with no re-referrals. Of the19 reviewed only 1 patient discontinued use of the device and 6 patients continued on additional ED treatments.
Discussion Vacuum devices are a well-tolerated treatment option in those who fail or are deemed unsuitable for other treatments. To date, reported outcomes have been excellent with only 1 patient discontinuing use.

P176 CLINICAL PHARMACOLOGY OF THE HIV INTEGRASE STRAND TRANSFER INHIBITOR BICTEGRAVIR

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10.1136/sextrans-2017-053232.219

Introduction Bictegravir(BIC), an investigational, once-daily, HIV integrase strand transfer inhibitor(INSTI) with potent in vitro activity against most INSTI-resistant variants, is currently in development as a single tablet regimen(STR) coformulated with FTC/TAF.
Methods BIC exposure was dose proportional following SD of 25–100mg. Steady-state accumulation was approximately 1.6x, consistent with the observed half-life of approximately 18 hours. Balanced glucuronidation and oxidation contributed to the major clearance pathways. The DDI study showed increased BIC AUC(61-74%) by CYP3A4 inhibitors voriconazole and DRV/COBI but showed a greater increase(~4x) by potent dual inhibitors of UGT1A1 and CYP3A4, ATV and ATV+COBI. Coadministration with a potent CYP3A4/UGT1A1/P–gp inducer, rifampin resulted in a 75% decrease of BIC AUC a lesser reduction(38%) was associated with the moderate CYP3A4/P–gp inducer, rifabutin. BIC was well tolerated at all doses studied.
Results The favourable BIC PK profile supports once daily dosing. DDI results are consistent with its ADME profile in which both CYP3A4 and UGT1A1contributed to BIC elimination. BIC was safe and well tolerated in healthy volunteers.
Discussion The favourable BIC PK profile supports once daily dosing. DDI results are consistent with its ADME profile in which both CYP3A4 and UGT1A1contributed to BIC elimination. BIC was safe and well tolerated in healthy volunteers.

P177 D2B OR NOT D2B: A REGIONAL MULTICENTRE SURVEY IN LEVEL 3 GUM CLINICS OF 'OTHER CONDITIONS REQUIRING TREATMENT'

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10.1136/sextrans-2017-053232.220

Introduction Diagnoses in patients attending GUM clinics are coded using SHHAPT codes. D3 is used for conditions not requiring treatment. It is often taken to mean a negative STI screen; however the code may not reflect the time or expertise required for a consultation with a high risk or anxious individual. The D2b code is used for 'other conditions requiring treatment' for which there is no other appropriate SHHAPT code. D2b codes did not attract funding in the SRH tariff.

This survey aimed to identify the range of complex consultations and non-STI work seen in GUM clinics that were not captured by the coding.
Methods A retrospective case notes review of patients with a D3 or D2b code attending GUM clinics in 2011. Data was gathered on socio-demographic details, SHHAPT codes and other diagnoses, and outcome. The data was analysed using Excel.
Results 594 patients were included (339 D2b, 255 D3). The commonest diagnoses were genital dermatoses 129(22%). Other diagnoses included chronic pelvic and vulval pain (27), other gynaecological and urological conditions (23), prophylaxis of recurrent infections (33), psychosexual and complex consultations including high risk sexual behaviour, sexual assault, and safeguarding referrals (65).
Discussion Following this survey, a list of D2b sub-codes was developed for use in all the regional GUM clinics. Since then, SRHAD codes have been introduced for complex dermatology, urology, and gynaecology conditions. However the continued use of the D2B sub-codes for high risk patients and complex consultations provides valuable data to support commissioning.

P178 TRAUMATIC RECTO-VAGINAL FISTULA AFTER CONSENSUAL SEXUAL ACTIVITY: A CASE SERIES

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10.1136/sextrans-2017-053232.221

Introduction Consensual vaginal intercourse may be associated with relatively minor genital injury, such as mucosal abrasions, tears or ecchymoses. More severe genital injury is more likely to be associated with rape or sexual assault by penetration with an object. Conversely, we know that the absence of genital injury does not mean that rape or serious sexual assault did not occur.
Methods We report a small series of patients presenting with severe and life-threatening genital injury after consensual sexual activity.
Results An adult woman presented with lower abdominal pain and faeculent vaginal discharge after sexual activity with her intimate partner involving consensual and simultaneous insertion of two sex toys (one *per rectum* and another *per vaginam*). She had sustained a 100mm defect in the posterior vaginal and antero-lateral rectal walls. Despite surgery and faecal diversion, she developed severe sepsis that required extended critical care.

A second patient presented with faeculent discharge *per vaginam* after consensual, 'conventional' peno-vaginal intercourse. On examination, she was found to have a 30 × 20 mm low recto-vaginal fistula; on this occasion not associated with peritoneal contamination or serious septic response.
Discussion Traumatic recto-vaginal fistulae are rare with implications for both immediate morbidity and mortality and long-term physical and mental well-being. These cases demonstrate the extreme spectrum of genital injury that may be associated with consensual sexual activity. Recognition that this severity of injury can occur following consensual activity is important and our first patient's story also highlights some of the public health implications concerning the use and regulation of sex toys.

P179 ERECTILE DYSFUNCTION CLINIC: EXPLORING DRIVERS AND BARRIERS TO SEEKING HELP

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10.1136/sextrans-2017-053232.222

Introduction Erectile dysfunction (ED) may affect up to half of men in their lifetime. Barriers can prevent discussion of symptoms with their GP and on occasions they will present at GUM clinics. Understanding these barriers can be useful in assessing their experiences and expectations of treatment.
Methods Anonymous self-administered questionnaire issued to new patients attending ED clinic. The Sexual Health Inventory for Men (SHIM) score used to classify ED severity.
Results 75 patients with median age of 52 years (range 19–78 years) participated. 93% had significant co-morbidities or vascular risk factors. In regard to SHIM, 47% classified as severe ED, 16% moderate, 26% mild-moderate and 11% mild. Duration of ED prior to attendance was greater than 5 years in 53% of patients. 50% reported significant impact on quality of life and notably 40% had underlying depression and/or anxiety. Seeking treatment was important/very important in 96%. Relationship difficulties prompted 65% patients to seek help. Barriers to seeking treatment included embarrassment in 47% and lack of treatment awareness in 29%. Initial discussion about ED was prompted by the patient in 85%. Regarding support, 73% discussed the issue with their partner and 16% with a friend/relative. 7% self-sourced treatment prior to attendance. The majority of patients (88%) reported limited knowledge of ED with 77% suggesting patient information leaflets would be useful prior to clinic attendance.
Discussion Patients presenting with ED often delay seeking advice. Medical comorbidities, relationship difficulties and embarrassment are significant issues affecting patients which should be taken into consideration during consultations.

P180 UNUSUAL CAUSES OF GENITAL ULCERATION PRESENTING TO GENITOURINARY MEDICINE CLINIC – A CASE SERIES

Emma Kinghan*, Stephen Megarity, Emma McCarty.

10.1136/sextrans-2017-053232.223

Introduction Genital ulceration presents frequently at GUM clinics, with herpes simplex (HSV) infection a common aetiology. A diagnosis of HSV is distressing with possible implications for relationships and future pregnancies. It is therefore important to consider other causes if atypical presentation or negative HSV PCR from area of active ulceration.
Method Case review of uncommon aetiologies of ulceration.
Results Case 1: 25 year old. Prodromal sore throat and flu-like symptoms. Examination revealed deep ulcers on vulva and oral mucosa without eye or skin involvement. CRP 120, ESR 80, ASOT titre 400, negative autoimmune screen, monospot negative. Developed anterior uveitis and erythema nodosum 24 hours later. Diagnosed with Behcet's disease requiring prednisolone and mycophenolate mofitil.

Case 2: 28 year old. Prodromal sore throat and headache. Sexual history atypical for HSV. Known Graves' disease, on propylthiouracil. On examination, patient looked unwell. Shallow vulval ulceration noted. Neutrophils 0.1, ESR 31. Diagnosed with apthous ulceration secondary to neutropenia and admitted for neutropenic-sepsis treatment. Required thyroidectomy with pathology revealing papillary carcinoma.

Case 3: 13 year old referred by SARC. No history of sexual contact or features of child sexual exploitation. Prodromal flu-like illness. Of note, mother Influenza A positive.

No response to empirical acyclovir. HSV PCR negative. Nasopharyngeal swab confirmed Influenza A. Case subsequently closed with SARC and Social Services.
Discussion This case series highlights less common but important causes of genital ulceration. Full systemic history and clinical assessment remains essential in those where alternate diagnoses to HSV are being considered.

P181 IS PROMOTION OF BLOOD DONATION IN THE GU CLINIC ALL IN VEIN?

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10.1136/sextrans-2017-053232.224

Introduction In the UK less than 3% of the population donate blood. The blood donation service faces a constant challenge

of recruiting new donors and stocks remain at critically low levels.

The histories we take in genitourinary (GU) clinics match closely with screening questions asked by the donation service and we wanted to explore whether there would be any value in utilising this similarity in promoting blood donation to our often young and otherwise healthy patient population.

Methods We conducted a prospective review of 100 consecutive patients seen during clinic, adding one extra question (regarding recent travel) to our usual history proforma to match the screening questions.

Results Of the 100 patients 25 (25%) would never be able to donate blood (18 sexually active men who have sex with men (including 4 with HIV), 6 with precluding health conditions, 1 ex-intravenous drug user). There were 13 (13%) not eligible to donate blood for up to 12 months (9 'high risk' sexual contact in last 12 months, 2 travel related, 1 pregnant, 1 on PEP post needlestick). Of these and the remaining eligible patients (62%), only 18 (24%) have donated (or attempted donation) previously.

Discussion We may not think of a GU clinic as a location to identify blood donors, however we found that 75% of the patients seen were potentially eligible. No additional time was needed to identify potential donors and only a brief intervention or posters in the clinic could be used to promote or signpost blood donation.

P182 CHLAMYDIA POSITIVE TESTING TO TREATMENT TURNAROUND TIME (TAT) APRIL TO DECEMBER 2016

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10.1136/sextrans-2017-053232.225

Introduction Reduction in time to treatment for those with STIs is key for reducing negative sequelae, identifying and treating STIs in partners and preventing onward transmission. BASHH 2014 Standards stipulate that results should be available within 10 working days of testing but there are no standards published for time from test to treatment. In our service patients are told to access results after 7 days. Our results management team contact untreated patients 7 days after testing.

Aims To ascertain the time period between STI test date, availability of result and receipt of treatment for those testing positive for chlamydia within a large multi-site service.

Methods A retrospective audit of the sexual health service electronic patient record (EPR) was undertaken from April to December 2016 identifying all chlamydia positive results across our service. Date of test, availability of result and treatment received was analysed. The following data was analysed.

Results 2897 patient records were identified for analysis. 550 were excluded due to incomplete data. 2347 records were analysed. 63.9% of results were available in 72 hours (mean 48 hours) and 96.2% in 7 days. 51.7% were treated within 48 hours of result availability, 56% within 7 days, 92.2% within 14 days and 97.5% by 28 days.

Discussion The majority of results are available within 72 hours however <60% of patients were treated within 5 days. Patients will now be advised to access the results within 3 days and the service will contact untreated patients within 5 days of a positive result.

P183 RETROSPECTIVE ANALYSIS OF THE UTILISATION OF SCROTAL ULTRASOUND SCAN IN SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.226

Introduction Most scrotal/testicular symptoms and signs are benign. US Scan is investigation of choice in these patients. However, several studies have shown ultrasound scan findings rarely changes management of these patients. Our aim was to understand how ultrasound scan influenced the diagnosis and management of men with scrotal or testicular symptoms seen in our sexual health clinic.

Methods Retrospective data collected from clinical records of all men seen in sexual health clinic and referred for US scan between 2010 and 2016. Data collected include age, presenting symptoms, STI screen, clinical and ultrasound finding.

166 men had ultrasound scan. 23 men excluded due to incomplete data. Data collected and analysed for 143 men.

Results Median age was 33 years (range 15 – 72 years). Common scrotal/testicular symptoms were: lump 72 (50%), aches/pain 45 (31.5%), others 15 (10.5%). Ultrasound scan diagnoses were: Benign epididymal or tunica albuginea cyst 40 (28%), Varicocele 25 (17.5%), Hydrocele 15 (10.5%), Normal 34 (24%), other 26 (18%), Cancers (testicular 2 and sarcoma 1) (2%). 7 men were referred to urologist for cancer treatment and embolization of varicocele.

Discussion Most men had benign scrotal conditions or normal findings confirmed on scan. This did not change their management plan. Two cases of testicular cancers were initially suspected on clinical examination.

P184 ADHERENCE TO PCP PROPHYLAXIS GUIDELINES IN HIV POSITIVE PATIENTS

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10.1136/sextrans-2017-053232.227

Introduction Pneumocystis Pneumonia (PCP) prophylaxis is often continued despite acceptable CD4 counts in HIV positive individuals on antiretroviral (ARV) treatment. Both BHIVA and EACS guidelines advise discontinuing prophylaxis if the CD4 count is >200 cells/mm3 for 3 months, EACS additionally states that prophylaxis should be stopped if the patient has a CD4 count of 100-200 and an undetectable Viral Load (VL) for 3 months.

Methods We analysed the case notes of all individuals actively receiving Co-trimoxazole prophylaxis prescriptions, and assessed clinical details, CD4 count and VL data to decide whether their continued prescription was in accordance with current guidelines.

Results We identified 32 patients, 27 male, currently on Co-trimoxazole prophylaxis. 18 individuals (56%) met the criteria for continuing PCP prophylaxis. Of the remaining 14, 3 individuals were on immunosuppressive medications for co-morbidities, and were therefore appropriately receiving prophylaxis. 11 of 32 individuals (34%) were found to be receiving Co-trimoxazole despite meeting guidance for discontinuing prophylaxis. 8 of these patients met the BHIVA guidelines, while an additional 3 met the EACS guidelines.

Discussion Our results suggest a significant number of individuals currently receiving PCP prophylaxis could stop. This would reduce their pill burden and minimise the effects of polypharmacy, as well as reduce cost to the NHS. Clinicians should therefore regularly review the need to continue PCP prophylaxis.

P185 SEX & RELATIONSHIPS EDUCATION (SRE): FOCUSING ON THE POSITIVES

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Introduction With the focus of SRE mainly unwanted pregnancies and STIs, due to the growing statistics, is that enough to educate and empower young people (YP) to help reduce them, or should we focus on the positives, like sexual pleasure and what sex actually is, to really engage young people and motivate behaviour change? In 2014, while working for a sexual health charity in West London, a College student approached the mobile sexual health clinic that I partnered with to encourage young people to STI test. He concluded that SRE was too 'negative' and just about STIs and unwanted pregnancies and so I invited him to help me develop a resource that makes SRE more 'positive'. Preceding that incident, 'Talking to Young People about sexual pleasure' training facilitated by Sussex University Researcher, Ester McGeeney (EM), was attended.
Methods In partnership with the student and EM, we put together a questionnaire to gather qualitative research to find out what YP want from SRE and what they understood about good and bed sex. From July 2014 – Dec 2015, 297 young people (148 females, 148 males, 2 unknown) were interviewed anonymously at 14 locations (6 × YP Hostels; 4 × Youth Centres; 2 × YP Charities; 3 × Colleges) with the majority of those YP residing in West London (60%; 25% from South; 2% from North; 5% from East London and 8% unknown). The majority of the participants were BME (56% Black; 5% Asian; 23% Other) with 12% from a White background and 4% unknown.
Results The top 4 topics that the YP wanted to know about, are already on the curriculum – Relationships (13%); Safe sex, condom use & negotiation (12%); STIs (12%); Being ready for sex/Consent (10%). However, the topics of Pleasure (7%) and the act of sex (8%) weren't far behind. The top 6 answers on what the YP understood what good sex was included Pleasure/Satisfaction (23%); Having a connexion (13%); Feeling/Being in Love (11%), Safe sex (10%); Mutual Feelings (9%); Passionate (8%). The top 5 answers on what YP understood what bad sex was, included Rape (18%), Mechanical/No feelings/Just for pleasure (15%); Unsatisfying/Incompatible/Disappointing (14%); Too quick/Premature Ejaculation (11%); Unprotected sex.
Discussion This shows that if YP know that good sex is about pleasure and having a connexion with someone, and bad sex involves no consent, no pleasure and no feelings, then surely we need to be adding more about sexual pleasure and how this relates to healthy relationships and consenting to sex, to SRE?

P186 THE USEFULNESS OF DIAGNOSTIC GENITAL SKIN BIOPSIES IN GENITO URINARY CLINICAL SETTINGS

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Introduction It can be difficult to ascertain the exact aetiology of genital dermatoses as there are a several causative factors including inflammatory, neoplastic & infective. Genital skin biopsy can be a useful tool to provide definitive diagnosis.
Methods We reviewed the electronic patient records of patients diagnosed with genital dermatoses in our clinic over a six month period. We compared clinical diagnoses with final histological diagnoses.
Results A total of 56 patients were given a clinical diagnosis of genital dermatosis during the study period – Lichen Planus (8), Lichen Sclerosus (27), Seborrheoic Keratosis (1), Psoriasis (5), Zoon's Balanitis (7), malignancy (3) and atypical lesions (5). Of these, 32 (57%) underwent a genital biopsy (see table one). Clinical and histological diagnosis correlated in 21 cases (66%). No additional malignant lesions were found following biopsy.
Discussion In our clinic, correlation between clinical and histological diagnosis of genital dermatoses was good and no additional malignancies were found over and above clinical suspicion. 32 patients (57%) of patients seen with genital dermatoses underwent a genital skin biopsy.

Abstract P186 Table 1 Genital Dermatoses

Clinical Diagnosis	Number	Number Biopsied	Clinical Diagnosis Confirmed
Lichen Planus	8	05	03
Lichen Sclerosus	27	13	08
Sebhorreic Keratosis	01	01	01
Psoriasis	05	04	03
Zoon's Balanitis	07	05	04
Malignancy	03	03	01
other	05	01	01

P187 ABSTRACT WITHDRAWN

P188 AN AUDIT OF MANAGEMENT OF PATIENTS PRESENTING WITH URINARY TRACT INFECTION (UTI) IN A SEXUAL HEALTH CLINIC

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Introduction Patients with symptoms suggestive of UTI is a common presentation in sexual health clinics.
Methods Laboratory data retrospectively identified all patients who had a MSU sent from May 2015 to October 2015. Data was retrieved from Electronic patient records and analysed using Excel.

Results There were 150 patients, 107 females and 43 males. Median age 32 years and range 16 – 74 years. Ethnicity: 36% were White British and 22% black Afro-Caribbean. 5 were female sex workers, 3 MSM and the rest heterosexual. 98% were symptomatic (104 had dysuria and 43 increased urinary frequency). 92% had 1 partner in the preceding 3 months.

Urinalysis was positive for leucocytes in 71, Nitrites in 55 and blood in 38 patients.

The audit standards our service achieved were: 84% of all patients who had symptoms suggestive of UTI had Urinalysis, 88% received appropriate first line antibiotics, 63% of women with pelvic pain had a pregnancy test and 100% of all male patients with a UTI were referred to Urology. 40% of MSU were positive and bacteria isolated were 73% E coli, 15% Coliform and 6% Proteus.

The table below shows sensitivities to antibiotics:

Abstract P188 Table 1 UTI antimicrobial sensitivity

	Trimethoprim sensitivity	Nitrofurantoin sensitive
Sensitive	80%	91%
Resistant	17%	9%
Intermittent	3%	0%

Discussion We are currently discussing with our local microbiologists about stopping routine MSU in line with NICE guidance and a change to nitrofurantoin as first line treatment. Staff training has been done to remind staff about the need to do a pregnancy test in women with pelvic pain.

P189 REFLECTIONS ON SCHOOL SEX EDUCATION FROM YOUNG ADULTS: A SURVEY VIA SOCIAL MEDIA

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10.1136/sextrans-2017-053232.231

Introduction With inconsistency of sexual education in schools, we used social media to ascertain opinions from a group aged 18-25 in the UK.

Methods A short survey of four questions was distributed via Facebook to immediate contacts to the primary author. 91 anonymous responses received (demographics not available).

Questions were • Which topics were covered in your sex education during your time in school?

• When do you think it is appropriate to begin sex education?

• Which areas of sexual education would you like to see improved?

• Is there anything that you wish you had been told during your sexual education?

The first two were multiple choice; second two were free text.

For analysis, 'sex education' was used as an umbrella term for education relating to sex (anatomy and practice), relationships, gender and sexuality. Responses for questions 3 and 4 were combined as they generated similar results.

Results Question 1:

Abstract P189 Table 1

Topics	Responses	Topics	Responses
Anatomy of sex	81(89%)	Consent and rape	26(29%)
STDs	79(87%)	Sexuality	14(15%)
Safe sex	77(85%)	Sexual harassment	11(12%)
Female contraception	58(64%)	Gender identity	3(3%)
Drugs and alcohol	58(64%)	Non-heterosexual intercourse	2(2%)

63/91 (69%) believed sexual education should begin during primary school. 31/91 (34%) wished that consent had been covered better, often combined with the implication that this lack of education had affected their personal life.

Discussion While not without limitations, our short survey gave some interesting results worthy of further exploration, suggesting that UK sexual education needs reform before it meets the needs of modern young people.

P190 GENITOURINARY MEDICINE: MORE THAN JUST STI SCREENING AND TREATMENT

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10.1136/sextrans-2017-053232.232

Introduction Since the transfer of commissioning, some local authorities have taken a narrow view of sexual health, defining it as STIs and contraception only, and some have not funded the complex non-STI genital conditions that are a core part of GUM. However patients attend because they have a problem, which may or may not be an STI, that affects their sexual health. We aimed to give a snapshot of a GUM consultant's clinical caseload.

Methods A record was kept of all GUM patient consultations over a 2 week period.

Results A total of 43 patients were seen. All but one were follow-ups. Nine (21%) were long-term attenders. The rest were referred by other clinic staff 20 (47%), consultants in other specialties 10 (23%) and GPs 4 (9%). The average age was 41 (19–87).

The commonest conditions seen were genital dermatoses (20), chronic/recurrent PID (13), recurrent candida (9; two with resistant species), VIN (6), atrophic vulvo-vaginitis (6), vulvodynia (5), and CPPS (4). STIs included HSV (3), chlamydial PID (3) SARA (1) and conjunctivitis (1), and an MSM with syphilis, rectal gonorrhoea and warts.

Nine patients had more than one genital infection and nine both a genital infection and a genital dermatosis.

Discussion This snapshot demonstrates both the complexity of patients and the holistic care provided by a GUM consultant. While other specialties are able to manage some of the conditions seen in GUM, few would have the expertise to manage patients with co-existing STIs and other genital infections, chronic pain conditions and genital dermatoses.

P191 PREVALENCE AND IMPACT OF MUSCULOSKELETAL PAIN AMONG STAFF WORKING IN A LARGE INTEGRATED SEXUAL HEALTH SERVICE IN UK

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Introduction Musculoskeletal pain (MSKP) is common and contributes to sickness absence among people of working age. Little is known about the occurrence of MSKP in staff working in Sexual Health (SH).
Methods SH staff working in a large integrated service completed a questionnaire exploring MSKP at several different anatomical sites, its severity and impact on work and personal life.
Results 39/80 (49%) questionnaires were completed. One staff member reporting pre-existing MSK problems was excluded. 92% respondents were female. 61% of doctors and 85% of nurses reported MSKP. Low back (LB) pain was more common in nurses (76%) than doctors (27%). However, involvement of single or multiple sites and overall impact were comparable for both groups. Those with/without pain were not significantly different in terms of age, median time working in SH or types of routine procedures. The most common site of pain was LB (54%). Pain intensity was on average moderately severe during the day (29%) and more severe at night (46%). Moderate to fairly severe impact was reported for work/daily routine (34%), social activities/hobbies (29%), sleep (29%), fatigue/low energy (26%) and emotional wellbeing (23%).

In terms of impact including seeking healthcare, using analgesia, missing work and interference with normal/recreational activities the most common sites implicated were LB, neck and hand pain in that order.
Discussion MSKP is very common among SH staff and causes significant impact professionally and personally. Reassuringly, symptoms were not markedly associated with any particular clinical procedure.

Public Health, Epidemiology and Partner Notification

P192 SYNDEMICS AMONG GAY, BISEXUAL AND OTHER MEN WHO HAVE SEX WITH MEN IN THE UNITED KINGDOM AND THE REPUBLIC OF IRELAND: EMPIRICAL EVIDENCE OF CLUSTERED HEALTH INEQUALITIES

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10.1136/sextrans-2017-053232.234

Introduction Gay men experience a multiple burden of ill health in relation to sexual health, mental health and substance use and there is growing recognition that these could cluster as *syndemic* health inequalities. Few studies (outside the USA) have addressed the co-occurrence of such negative health outcomes. We examine empirical evidence of syndemic health outcomes in an online cross-sectional survey of MSM.
Methods Self-report data on sexual, mental and physical health outcomes from the SMMASH2 survey of 3373 MSM in Scotland, England, Wales, Northern Ireland and the Republic of Ireland in 2016 were used to derive a measure of syndemic ill health.
Results Overall, 68.2% reported at least one sexual health outcome, 60.4% reported at least one mental health outcome, and 61.0% reported at least one physical health outcome. There was significant co-occurrence of outcomes, with 67.0% reporting multiple health outcomes; 42.0% reporting two, and 27.0% reporting all three. There was statistically significant clustering of the behaviours at all levels. When examining all three outcomes concurrently, all were clustered with greater prevalence than expected if the outcomes where independent (O/E Ratio=1.07; 95% Confidence Interval 1.004 –1.14).
Discussion Clustering of poor sexual, mental and physical health provides evidence of syndemic health inequalities in communities of gay, bisexual and other MSM surveyed online (at levels significantly higher than the nationally estimated prevalence of 8.4%). Current health improvement efforts are often characterised by disjointed services, which should be reconfigured to ensure a holistic approach to addressing the complex, multi-faceted, interrelated issues affecting these communities.

P193 MAKING ONLINE CONTACT COUNT: ADDRESSING HEALTH NEEDS IN UNDER 18S ATTENDING SRH

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10.1136/sextrans-2017-053232.235

Introduction The Five Year Forward Review calls for an upgrade in prevention and public health and Making Every Contact Count suggests utilisation of provider encounters to enable positive behavioural change. The London Sexual Health Transformation Programme will be implemented in April 2017 and it is proposed that asymptomatic patients will access services online rather than attending a clinic.
Methods In the financial year 2015 – 16 there were 1975 attendances of 998 individuals <18 at a sexual & reproductive health service. A risk assessment proforma was used in 98.82% (n=505/511) of those 16 or under and 72.9% (n=355/487) of those aged 17. These were analysed using an electronic report.
Results Current mental health problems, smoking, drug and alcohol use was recorded in 837 (97%), 694 (81%) and 818 (95%) records respectively.

Abstract P193 Table 1 Under 18s attending SRH

	Under 16 n=205	Age 16 n=300	Age 17 n=355
Mental health difficulties	47 (23%)	63 (21%)	93 (26%)
Smoking	70 (34%)	85 (28%)	122 (34%)
Alcohol use alone	67 (32.7%)	124 (41.3%)	128 (36%)
Drug use alone	5 (2.4%)	12 (4%)	10 (2.8%)
Drug + alcohol use	14 (6.8%)	18 (6%)	31 (8.7%)

Discussion Mental health difficulties, smoking, drug and alcohol use are common across all ages. Assessment enables health promotion through brief interventions and is important to

identify young people at risk; commissioners should ensure that opportunities are not lost with online access. We suggest commissioning of a one stop shop model for under 18s or robust online screening protocols to ensure opportunities for intervention are not lost.

P194 ROLLING OUT THE UK'S FIRST REGIONAL MSM HPV VACCINATION PROGRAMME: EARLY EVALUATION AND PRACTICAL CONSIDERATIONS

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10.1136/sextrans-2017-053232.236

Introduction The four countries in the UK had different interpretations of the JCVI HPV vaccination recommendations. We aim to describe our experience to date of the full vaccination programme that commenced in our region in October 2016.
Methods We conducted a retrospective review of our opportunistically-offered vaccination programme, using both electronic and paper records.
Results From October 2016 until end January 2017, 827 vaccines were administered to 609 patients. The records of 274 vaccinees were analysed. 59% were HIV negative, 41% positive. 99% were MSM, aged 18 – 67, 12% were over 45, 43% were diagnosed with an STI or had PEP in the preceding 6 months, 74% had no documented history of genital warts. 11% attended solely for the HPV vaccine at their second visit. 91% of HIV positive patients re-attended for their second vaccine at their usual HIV clinic appointment. An estimated completion rate, calculated using those who re-attended as planned at one month and received a second vaccination, was 83%. For the HIV positive cohort, this was higher still at 95%.
Discussion We found that opportunistically vaccinating this cohort resulted in only 11% of all second attendances being solely for a HPV vaccine, and only 6.5% in the HIV positive cohort. Our completion rate, calculated using data at one month, was high. We aim to present a full six months of data.

P195 HOW PREPARED ARE GUM AND HIV CLINICS IN LONDON TO RESPOND TO THE HEPATITIS A OUTBREAK? A SURVEY OF VACCINATION POLICY AND LOGISTICS

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10.1136/sextrans-2017-053232.237

Introduction From late 2016, Hepatitis A virus (HAV) infection in MSM increased in incidence in the UK and has reached outbreak status. By February 2017, 42 confirmed or suspected cases had been reported in London. An outbreak committee was convened by Public Health England and as part of this work data was gathered to ascertain current levels of vaccination and future needs in MSM attending GUM/HIV clinics.
Methods Clinical leads for GUM and HIV services in London were e-mailed a survey asking about past HAV vaccination policy, requirements for vaccine, logistics of vaccine provision, acute HAV infection reporting and contact tracing policy.
Results 14/17 (82%) NHS Trusts, representing 23 clinics responded to the survey.

Abstract P195 Table 1 HAV Vaccination Provision for MSM in GUM and HIV clinics in London

Never stopped in GUM	Stopped in GUM in last 2 years	Stopped in GUM in last 2–10 years	Stopped in GUM >10 years ago
3/23 (13%)	6/23 (26%)	7/23 (30%)	7/23 (30%)
Offered to all HIV+ patients		**Offered to selected HIV+ patients only**	
20/23 (87%)		3/23 (13%)	

4/23 (17%) GUM clinics restarted routine vaccination in 2017. Only 3 HIV clinics were able to estimate background HAV immunity in their MSM as being 70–90% immune/vaccinated. The barriers to roll out of vaccination were identified as cost/funding (17/23 74%); logistics of provision (11/23 48%) and vaccine supply difficulties (7/23 30%). All clinics would contact trace acute HAV cases internally, 6/23 (23%) would notify the Health Protection Team by phone and the rest would notify using the BASHH/PHE notification form.
Discussion The provision of HAV vaccination for MSM in London GUM clinics has been variable, leading to a significant proportion of MSM potentially remaining non-immune. The main barriers to vaccination have been funding, logistics and vaccine supply. If the outbreak is to be halted, these barriers need to be overcome.

P196 THE COST TO FIND ONE CASE OF SYPHILIS

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10.1136/sextrans-2017-053232.238

Introduction Cost effectiveness is an important consideration especially in the context of constrained budgets. For the National Chlamydia Screening Programme, doubling Partner Notification (PN) was modelled to reduce the cost per diagnosis by £60 and improves gender equity (Turner et al, BMJ. 2011; 342:c7250. doi: 10.1136/bmj.c7250); however, it is not known how PN impacts on a less common but growing Syphilis epidemic. We therefore looked at the impact of PN for patients with Syphilis using a new PN tool.
Methods The Syphilis diagnoses and testing for one year from February 2016-2017 were determined for two clinics, prices for testing and PN were derived from the integrated sexual health tariff (www.pathwayanalytics.com) and PN data was obtained from SXT (www.sxt.org.uk).
Results The Syphilis incidence was 257/30,641 and the cost of a full screen £75; consequently, the cost per Syphilis diagnosis was £8,941. Ten percent of patients coded as partners were found to be infected with Syphilis. The PN outcomes of 248 (96%) patients with early infectious Syphilis were known: 132 partners were verified as seen and tested (KPI=0.53), representing 13 new diagnoses. The cost to deliver PN was £4903 [248*(£17.33 tariff & £2.40 SXT)] and ten partners need to test at £750 [10*£75] to diagnose one case, making the

overall cost per Syphilis diagnosis £5,653. PN initiated testing was estimated to reduce the cost per syphilis diagnosis by £3,288.

Discussion PN services reduce the cost to diagnose Syphilis and support case finding. More work is required to target testing and improve PN.

P197 AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS TO EXPLORE THE EXPERIENCES OF PATIENTS AFTER SPEAKING WITH A HEALTH ADVISER ABOUT PARTNER NOTIFICATION

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10.1136/sextrans-2017-053232.239

Introduction Partner notification (PN) is pivotal in controlling spread of sexually transmitted infections (STI) by reducing onward transmission and preventing reinfection. We explored the experiences of patients undergoing PN after being diagnosed with a STI.

Methods 259 patients diagnosed with a STI over a 3 week period were invited to complete a PN survey comprising quantitative and qualitative questions. Qualitative data was analysed using Interpretative Phenomenological Analysis (IPA).

Results 76 patients, 20 female and 24 male responded (not all questions were answered). Mean age was 31 (range 16-58). 21 identified as single and 16 partnered. 29% said this was their first clinic attendance, 65% said this was their first ever STI diagnosis and 36% said they attended as a STI contact. Eight main themes were identified: (1) infection source; (2) how to contact partners; (3) difficult information to discuss 'specific sexual acts performed with every one of them'; (4) uncertainty of partner testing and treatment; (5) concern of providing partner details; (6) future expectations; (7) use of social media; and (8) Health Adviser (HA) qualities. Patients understand PN, but face barriers due to partnership dynamics and lack the skills required for PN. Further partners were contacted following consultation with a HA. Evidence of alternative PN being offered (i.e. provider referral) was limited.

Discussion In line with BASHH guidelines, the importance of specialist staff in delivering PN was evident. Novel ways to facilitate sexual history taking and methods to contact partners (i.e. social media) are preferred and should be explored further.

P198 CHEMSEX AND ANTIRETROVIRAL THERAPY NON-ADHERENCE IN HIV-POSITIVE MEN WHO HAVE SEX WITH MEN: A SYSTEMATIC REVIEW

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10.1136/sextrans-2017-053232.240

Introduction Chemsex is associated with ART non-adherence and may therefore negatively influence HIV disease progression. However, there is no systematic examination of evidence for this association. Our objective was to summarise the extent of ART non-adherence among chemsex drug-using HIV-positive MSM worldwide and to quantify the effect that chemsex has on ART non-adherence by comparing chemsex drug-users to non-chemsex drug-users.

Methods Pubmed and Embase were searched from inception to 25.06.15. Prevalence and analytical studies were included. Bias was assessed using a risk-of-bias assessment tool. Assessment of heterogeneity was conducted using I2 and Cochran-Q Chi2 statistics. Metaanalyses were conducted using fixed or random-effects methods. Metaregression assessed for formal statistical evidence of heterogeneity.

Results 3288 published and unpublished records were screened. Prevalence of ART non-adherence among chemsex drug-users (10 studies) ranged from 6% to 81%. 7 studies provided 10 effect measures for the association between chemsex drug-use and ART non-adherence. Chemsex drug-users had 23% higher odds of being ART non-adherent compared with non-chemsex drug-users (OR 1.23, 95%CI 1.10–1.38, I2 0%, p=0.372). Studies that used less specific definitions of chemsex drug-use found weak statistical evidence for an association (OR 1.96, 95%CI 0.52–7.31, I2 78.9%, p=0.009). Meta-regression failed to provide statistical evidence of why the effect varied between studies.

Discussion In HIV-positive MSM, the prevalence of ART non-adherence among chemsex drug-users varied widely. There was evidence of an association between chemsex drug-use and ART non-adherence. Paucity of studies and substantial heterogeneity between studies limited interpretation of results. Further well-conducted studies in a variety of settings are needed.

P199 ARE WE TESTING IN THE RIGHT LOCATIONS? USE OF PUBLIC HEALTH MAPPING TO INVESTIGATE YOUNG PEOPLE, CHLAMYDIA AND SOCIOECONOMIC STATUS

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10.1136/sextrans-2017-053232.241

Introduction Chlamydia testing is universal and routine in all local sexual health clinics. Projected local population increases and expansion of the university sector necessitate the appraisal of current services and future planning to meet population need.

Objective To investigate whether the current locations of Chlamydia testing services match areas of high need.

Method We obtained data from the Sexual Health in Wales Surveillance Scheme (SWS) on Chlamydia diagnoses in integrated sexual health clinics by middle super output area (MSOA) of residence for patients living in our local area. Mapping software is used to overlay Chlamydia testing behaviour and positivity against locations of FE colleges, STI testing clinics, areas of high deprivation and areas with a high proportion of young residents.

Results Between 2012 and 2016, 3,450 chlamydia diagnoses were recorded in Cardiff and Vale residents. The maps suggest that Chlamydia diagnoses were most common in areas usually habited by students. Furthermore, mapping fifths of deprivation suggested lower rates of Chlamydia in the more deprived areas, despite more testing venues.

Discussion The maps suggest University students are frequent testers and have a high positivity for Chlamydia whereas those from more deprived areas have lower rates for Chlamydia. This descriptive analysis suggests that local chlamydia testing services may not be mapped to populations at greatest need.

This association is difficult to measure without a robust statistical test and more analysis is needed to quantify the association. Alternative testing paradigms outside clinic settings could help manage demand on clinical services.

P200 JUST GOOGLE IT! IMPACT OF MEDIA COVERAGE OF AN OUTBREAK OF HIGH-LEVEL AZITHROMYCIN RESISTANT GONORRHOEA ON ATTENDANCES, AND GONORRHOEA TESTING AND DIAGNOSES AT LOCAL SEXUAL HEALTH CLINICS IN ENGLAND

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10.1136/sextrans-2017-053232.242

Introduction We investigated whether media coverage of an outbreak of high-level azithromycin resistant gonorrhoea in England, dubbed 'super gonorrhoea', affected online searches nationally, and attendances and gonorrhoea testing and diagnoses at sexual health clinics (SHCs) in affected areas.
Methods Google Trends was used to determine Relative Search Interest (RSI) for 'gonorrh*' and 'super gonorrh*' in England from 2015 – 2016. Using data from England's national STI surveillance system, an interrupted time series analysis was performed to compare the sex-stratified, weekly rates of attendances, and gonorrhoea testing and diagnoses at 6 SHCs in Leeds and in five other affected areas. The analysis compared rates of events 6 weeks before and after initial media coverage of the outbreak in September 2015.
Results The RSI peaked during initial media coverage in September 2015 with smaller peaks coinciding with subsequent coverage. The number of SHC attendances by women in Leeds rose after initial coverage ($p<0.01$) by 36% (from 320 to 435/week), but there was only a 4% increase in attendances (from 326 to 340/week) by men ($p=0.70$). There was no change in rates of gonorrhoea tests or diagnoses in women ($p=0.87$ and 0.23) or men ($p=0.51$ and $p=1.00$). There were no significant increases in event rates in five other areas with a high RSI.
Discussion We demonstrate that media coverage can impact health-seeking behaviours during high-profile outbreaks. Further research is needed to inform how best to target these messages to those most likely to benefit from attending and being tested in SHCs.

P201 HOW CAN SEXUAL HISTORY TAKING FOR SEXUALLY TRANSMITTED INFECTION PARTNER NOTIFICATION BE IMPROVED?

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10.1136/sextrans-2017-053232.243

Introduction National guidelines, standards and policies help health care professionals to elicit information during sexual history taking as part of partner notification (PN) for sexually transmitted infections (STI). Accurate information about sexual partners and sexual behaviours is vital to prevent onward transmission. This study focuses on patients' experiences on how sexual history questions for the purpose of PN could be improved.
Methods We conducted 12 focus groups with members of the public and patients at sexual health clinics in Glasgow and London. All patient participants had been diagnosed with a (non-HIV) STI in the past six months. Data were analysed using thematic analysis.
Results Analysis revealed a number of interrelated themes arising from participants' experiences and perceptions. Shared beliefs about sensitivity and reflexivity of questions regarding the frequency, riskiness and contactability of sexual partners influenced the way in which patients experienced and responded in sexual health consultations. Congruence in language and clinician-led consideration of the context of individual sexual behaviour contributed to the extent to which information was shared.
Discussion Sexual history taking for PN is embedded within a complex interaction between clinicians and patients. The need to accurately identify all partners is balanced against acknowledging that questions asked must be sensitive yet unambiguous. This study suggests that establishing congruence in language and investing time to examine contextual factors within the patient's sexual behaviours can lead to active collaboration within a time-efficient window, and enhancing the accuracy of information shared thereby enabling health professionals to offer appropriate options for PN.

P202 INCREASE IN DIAGNOSES OF EARLY INFECTIOUS SYPHILIS: LOCAL OUTBREAK OR FOLLOWING THE NATIONAL TREND?

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Introduction There has been a substantial increase in the incidence of early infectious syphilis (EIS) in our large city clinic, apparent since reconfiguration of services in July 2015.
Methods A retrospective case note review of electronic patient records was undertaken to investigate whether this was due to a local outbreak or in keeping with recent national trend. A database search for primary, secondary & early latent syphilis identified 78 and 116 cases in 2015 and 2016 respectively. These records were assessed using BASHH audit standards and reviewed for various lifestyle risk factors. We worked with Public Health England to address concerns regarding a possible local syphilis outbreak.
Results Of 168 patients, 85% were MSM: 34% and 28% were HIV positive in 2015 and 2016 respectively. Of the patients with known HIV, 64% were diagnosed as part of their HIV care. Partner notification reached 0.56 contacts per index case. Of the 89 contacts, over 50% were positive for syphilis. Retrospective analysis of surveillance data identified a breakpoint in July 2014 associated with a monthly increase in cases since then with no observable change in patient demographics.
Discussion Service reconfiguration focussed on MSM risk groups, coincided with increased EIS diagnoses within 1 year. However, epidemiological analyses indicate a continuum from

2014 following national trend. Routine syphilis screening in HIV care remains an essential tool for early case finding. As 80% were first syphilis infections we are evaluating syphilis point of care testing alongside capillary blood sampling to increase screening in outreach settings.

P203 THE 'LEXICON OF LOVE': UNDERSTANDING TYPES OF RELATIONSHIPS AS PRIMARY CONTEXTS OF STI TRANSMISSION

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Introduction Social contextual factors are often not taken into account when examining STI transmission. Understanding relationship types is central to targeting sexual health services, such as partner notification. This study examines the public's understandings of the language used to describe different types of partners and sexual relationships.
Methods A qualitative study, involving six focus groups was conducted in Scotland and England. Purposive sampling recruited 38 participants, including young heterosexuals (n=22) and gay men and other men who have sex with men (n=16). A semi-structured topic guide was used to facilitate the discussion, which included interactive tasks. An integrative thematic analytic approach was adopted by synthesising both textual data and the data derived from the interactive tasks.
Results Findings highlighted the diverse ways that relationships are understood and the fluid nature of partner types. Themes illustrated the importance of a range of contextual factors such as the variable nature of sexual relationships and key differences in their affective elements, the importance of peer context, social identities and developmental trajectories and the role of online communication in developing and shaping sexual networks and partnership formation.
Discussion Social identities and people's historical and geographic context 'shape' the way people talk about relationships. Fluidity and contextualisation are two key elements to be taken into consideration in understanding the language and terms used to describe relationships. From a public health perspective, understanding relationship types can unveil pathways to understand transmission patterns of STIs and provide more effective sexual health services.

P204 A JUNIOR DOCTOR-LED PROGRAMME IS EFFECTIVE IN EDUCATING YOUNG PEOPLE ABOUT SEXUALLY TRANSMITTED INFECTIONS AND THEIR LOCAL SEXUAL HEALTH CLINIC

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Introduction It is well recognised that people aged 15–24 have the highest rates of sexually transmitted infections (STIs). In an area failing to meet national targets on chlamydia detection in this age group and overall HIV testing, junior doctors are delivering sessions to educate young people. The project aims to increase attendance at sexual health clinics and improve sexual health in this high-risk group.
Methods Since 2012 junior doctors have been visiting secondary schools locally to deliver a 50-minute teaching session to 14–16 year olds covering condom application, symptoms of STIs and accessing their local sexual health clinics. The sessions have received positive feedback from teachers and students. This year a questionnaire has been introduced to quantify pre and post teaching knowledge.
Results 188 children completed the questionnaire. Pre-teaching scores included 25.9% on STI symptoms, 34.9% on where the local clinic is and 27% awareness of what happens there. The post-teaching scores showed an improvement of 49.8%. 89% students reported feeling more comfortable discussing STIs following the session.
Discussion We have highlighted that there is a need to provide more information to 14–16 year-olds about the symptoms of STIs and their local sexual health clinic. We have also demonstrated that a junior doctor led programme is an efficacious method of delivering this. Education from a young age could contribute towards increasing screening and reducing STI rates.

P205 THE FUNCTIONALITY OF DATING APPLICATIONS IN SEXUAL RELATIONSHIPS AND SEXUAL HEALTH

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Introduction Dating apps are an increasing way people meet each other for sex and relationships. Their functionality captures aspects of contemporary sexual culture and reflects the ways relationships are understood. This study systematically assed dating app functionality in relation to sexual relationships and sexual health.
Methods We examined the top down-loaded 500 dating apps listed on a public platform of dating applications (App Annie). Following screening using inclusion and exclusion criteria, data were systematically extracted from included dating apps (n = 259). Data were collated regarding how the App functionality related to target population, and included links to sexual health interventions. We specifically coded how the Apps defined the kinds of relationship the app-user was in and the kind of relationship the app-user was looking for.
Results Forty percent of dating apps were designed for specific user populations defined by nationality, religion or sexual orientation and preference. Dating apps varied greatly in the ways their functionality reflected types of relationships (e.g, it's complicated', 'something long term', 'friends with benefits'). Only a minority of dating apps (4.2%) provided a link to sexual health information, interventions or referral to clinical service options.
Discussion This study can help clinicians to better understand the relationships people have, the words used to describe these relationships and the likely impact this has on sexual behaviours, onward transmission and potential partner notification interventions.

P206 PREVALENCE AND RISK FACTORS ASSOCIATED WITH CHLAMYDIA TRACHOMATIS (CT), MYCOPLASMA GENITALIUM (MG) AND NEISSERIA GONORRHOEAE (NG): CROSS-SECTIONAL STUDY IN THREE SEXUAL HEALTH CLINICS

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Introduction *Chlamydia trachomatis* (CT), *Mycoplasma genitalium* (MG), and *Neisseria gonorrhoeae* (NG) infections contribute to major reproductive health sequelae. CT and NG are routinely tested for in sexual health clinics (SHCs), whereas MG is not. Population prevalence estimates for males and females for CT and MG are >1% and <0.1% for NG infection. Risk factor data, which help target control interventions, are limited in men-who-have-sex-with-men (MSM). We assessed prevalence and risk factor data in symptomatic patients accessing SHCs.

Methods Patients aged ≥16 years with symptoms of an STI provided: vulvovaginal swabs (females), first void urine (men-who-have-sex-with-women (MSW) and MSM) and pharyngeal and rectal swabs (MSM). Routine clinic results were obtained and FTD Urethritis Plus kit used to detect MG. Risk factors (RFs) were analysed using univariate (UV) and multivariate (MV) logistic regression.

Results

Abstract P206 Table 1 Prevelance and risk factors associated with STIs

	Females n=305	MSW n=174	MSM		
			Urine n=79	Rectal n=80	Pharynx n=87
CT % (95% CI)	8.20 (5.61–11.82)	20.96 (15.43–27.47)	6.33 (2.73–13.97)	7.50 (3.48–15.40)	1.18 (0.21–26.80)
MG % (95% CI)	7.54 (5.08–11.06)	17.82 (12.84-24.18)	1.27 (0.22–6.83)	8.75 (4.30–16.98)	0.00 (0.00–4.23)
NG % (95% CI)	1.31 (0.51–3.32)	6.32 (3.57-10.96)	13.92 (7.96–23.24)	27.50 (18.92–38.14)	17.44 (10.86–26.80)

The only RFs associated with any organism in MV analyses was in females. Being aged 16–19, a contact of someone with an STI, and not bleeding were associated with CT and being a contact was the only RF for NG.

Discussion CT and MG positivity were highest in MSW compared with other patient groups, whereas NG positivity was highest in MSM, especially rectal samples. In the absence of routine MG testing, NG-positive MSM would be treated with 1 g azithromycin, (combined with 500 mg ceftriaxone) which could result in MG antimicrobial resistance development. From our study population, with no RFs for CT, NG or MG, a targeted test and treat approach would not be beneficial in MSW or MSM.

P207 OUTBREAK OF HEP A AFFECTING MSM: THE LONDON RESPONSE

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Introduction: Outbreaks of hepatitis A virus (HAV) have previously been described in men who have sex with men (MSM). BASHH only recommends HAV vaccination for MSM during outbreaks. A UK cluster of HAV cases was identified and, by 27/2/2017, London had 45 probable and confirmed cases in MSM. London sexual health commissioning is in flux with new arrangements imminent.

Methods: For individual notified cases, Health Protection Teams (HPT) routinely assess source, offer infection control advice to the case and organise vaccination of household and sexual contacts. A London outbreak control team (OCT) comprised epidemiologists, commissioners and providers of immunisation and sexual health services, health promotion partners and communications. The OCT scoped possible additional interventions to control the outbreak.

Results:

The OCT recommended: Awareness raising re risk behaviour: Distribute a nationally commissioned leaflet with safer sex advice to cases and to genitourinary medicine (GUM) clinics, plus relevant content on digital platforms.

Liaison with providers, commissioners: Inform GPs. Survey current practice in GUM for HAV immunisation. Vaccinate MSM opportunistically in GUM clinics (if had a new or casual partner in last 3 months).

Link with existing health promotion networks: Working with gay venues, to get understanding and cooperation.

Set up vaccination clinics near the popular venues

Discussion: It is challenging to set up an immunisation programme in a large city with complex commissioning relationships at short notice. Consideration should be given to vaccination between outbreaks to reduce the proportion susceptible, or 'outbreak ready' plans included in sexual health commissioning arrangements.

P208 IN AN ERA OF ANTIBMICROBIAL STEWARDSHIP IS EPIDEMIOLOGICAL TREATMENT FOR SYPHILIS STILL JUSTIFIED?

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Introduction The BASHH guidelines for syphilis recommend the offer of epidemiological treatment or re-screening at 12 weeks (12w) after exposure for asymptomatic sexual contacts. We reviewed local practice and compliance with guidance in view of the increasing need for antimicrobial stewardship.

Methods We conducted a retrospective case note review of patients coded as syphilis contact (PNS) between January 2015 and July 2016.

Results We identified 44 patients (40 [91%] male; 35 [80%] men who have sex with men) reporting syphilis contact. There were 12 (27%) symptomatic, who were all given treatment; 7

(63.6%) with subsequently positive syphilis serology. Of 32 (73%) asymptomatic patients 25 (78%) received treatment. All 25 reported ongoing sexual contact with the index partner or others within the window period (WP) and serology was consistent with active infection in 5 (20%). Of the 7 (21.9%) that didn't receive epidemiological treatment 5 were outside the WP and tested negative; 1 declined treatment and tested negative at 12w; 1 contact of late latent syphilis tested negative within the WP but failed to attend 12w follow up. There were 8 (18%) with other STIs at presentation.

Discussion While penicillin-resistant syphilis is not an immediate concern, contacts may have other infections that could be partially treated with penicillin based or tetracycline antibiotics potentiating resistance. Over half our patients were at risk of re-infecting or transmitting to partners supporting the basis for epidemiological treatment but should we consider the option of treating symptomatics at presentation and abstinence advice pending results?

P209 WHAT MAKES EXPEDITED PARTNER THERAPY (EPT) AND ACCELERATED PARTNER THERAPY (APT) WORK FOR PARTNER NOTIFICATION FOR BACTERIAL STIS? A SYSTEMATIC REVIEW OF INTERVENTIONS

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Introduction Expedited Partner Therapy (EPT) treats the sex partners of persons with STIs without prior clinical evaluation. These interventions have been shown to reduce rates of re-infection and treat a higher proportion of sex partners. EPT which includes remote medical assessment of sexual partners is known as Accelerated Partner Therapy (APT) and meets UK prescribing guidance. Understanding the sequential active behaviour change components of such partner notification (PN) interventions and their use of theory, enables their optimisation and translation to the UK health context.

Methods We searched eight databases for studies detailing EPT and APT interventions for STIs implemented in high-income countries which included process and outcome data. Abstracts were screened and full-text articles analysed. Data were extracted relating to population, context, intervention components and associated behaviour change techniques (BCTs).

Results We included 15 of 723 studies covering interventions implemented between 1996–2013 in the UK and USA. EPT interventions are composed of complex sequences of diverse components, representing heterogeneous 'relay' behaviour change interventions. They involve diverse behavioural targets and target populations (index patient, partners, healthcare professionals). However they employ a broadly consistent range of behaviour change techniques including: 'how to perform a behaviour' and 'information about health consequences.'

Discussion EPT interventions are atheoretical, developed in response to patient and provider needs. Systematically identifying the key behaviour components and processes involved in EPT/APT may help explain intervention effectiveness. Developing an explicit theoretical framework using identified BCTs will help in training healthcare professionals to deliver EPT/APT, improving generalisability of interventions and PN outcomes.

P210 A CLUSTER OF INFECTIOUS SYPHILIS CASES

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Introduction In 2016 the Field Epidemiology Service (FES) noted an increase in cases of infectious syphilis reported to the Enhanced Syphilis Surveillance Scheme (ESSS) from our clinic. From 01 January 2016 to 31 December 2016, 55 cases were reported to ESSS; compared with 12 cases from January to December 2015.

Methods Data was extracted from GUMCAD and the ESSS. FES collated and analysed the data using appropriate measures of disease frequency, central tendency and spread in order to describe the epidemiological characteristics of the cluster.

Results

All cases were male The median age was 37 years (range 16 to 74). 75% were men who have sex with men (MSM), 18% heterosexual and 7% bisexual. 89% were of white British ethnicity. 64% were HIV negative. 18% reported chem-sex.

38% were diagnosed as primary syphilis, 36% secondary syphilis and 27% early latent syphilis.

Venue and/or web application information was recorded for 71% of cases. GRINDR was the most commonly mentioned application (48% of cases mentioning use).

Discussion In order to reduce syphilis transmission it is vital that new cases are identified and treated and strategies put in place to target populations at higher risk. Incident Management Team meetings were held in 2016 including representatives from Public Health England, GUM, sexual health promotion team and commissioners. Education and awareness programmes have been implemented focussing on specific websites, apps and venues such as bars and clubs popular among MSM. We continue to monitor cases of infectious syphilis on a monthly basis.

P211 TEENS AND SEXTING – A PUBLIC HEALTH CONCERN?

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Introduction Sexual messaging (sexting) has become a norm of peer-to-peer communication among young people. There are concerns about the negative impact sexting has on young people's health and wellbeing. However, little is known about the nature of public health messages currently being provided on sexting. This study sought to understand the nature of information and advice on sexting available online for children, young people and adults.

Methods A document analysis explored online resources from national agencies involved in promoting the welfare of children and young people. Thirty-eight documents were identified which included audio-visual files. The nature of information was analysed thematically.

Results Definitions of sexting, the scope of the problem and the role of technology were key themes across the documents. Safeguarding prioritised the welfare of young people with advice and scenarios on legal issues. Immediate and longer-term consequences considered peer pressure, coercion, bullying and control, psycho-social distress, reputation damage and internet related crime. Advice focused on how to say 'no', minimising risk, dealing with the problem, relationship advice, safety and harm reduction including how to use social media.
Discussion Sexting may play an important part in normative sexual development and sexual enquiry. Online digital relationships also create concern for some children and young people. This research found that there was a wealth of information and advice available and the nature of it is consistent across agencies. Harm reduction could be strengthened through a multi-agency commitment to promote inclusive, cross-curricular online safety and healthy peer relationship messages.

P212 THE CLAP TRAP: THE EFFECTIVENESS OF PARTNER NOTIFICATION FOR GONORRHOEA IN MSM IN AN LGBT COMMUNITY SEXUAL HEALTH CLINIC

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Introduction High rates of partner change, multiple casual partners, and complex sexual networks are thought to contribute to outbreaks of Neisseria gonorrhoea (GC) in men who have sex with men (MSM), who account for 42% of diagnoses in the UK. Prompt, appropriate treatment and effective partner notification are key to reducing transmission. We audited partner notification for GC in MSM attending an LGBT community sexual health clinic.
Methods A retrospective audit over 12 months (2015–16). A total of 33 episodes of GC were diagnosed in 31 patients. Data was recorded on a spreadsheet for analysis.
Results 25(76%) were asymptomatic. 29(88%) underwent triple site testing and 4(12%) dual site. Gonorrhoea was detected in the pharynx in 23(70%), urethra in 7(21%), and rectum in 14(42%). 7(21%) had dual and 2(6%) triple site infection. 29/33(88)% were informed of the diagnosis within 10 days (target 95%). 28/33(85%) were treated within 2 weeks. 6 attended as contacts of GC and were treated on the day they attended. A total of 109 contacts were given. 50 (46%) were untraceable. Of the traceable contacts, 31/59 (53%) were confirmed as treated, 23 at the same clinic. A total of 0.9 contacts were treated per index case (target 0.6).
Discussion The high frequency of unknown casual partners in MSM with GC means there is often inadequate information to trace partners. Nevertheless, this audit has shown good outcomes for partner notification in a community LGBT sexual health clinic. This should contribute to reducing onward transmission in a high risk MSM population.

P213 THE EPIDEMIOLOGICAL FEATURES OF HERPES SIMPLEX VIRUS CASES IN A CORK STI CLINIC

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10.1136/sextrans-2017-053232.255

Introduction Herpes simplex virus (HSV) is the leading cause of genital lesions worldwide. The transmission of sexually transmitted infections (STI's) and human behaviour are intrinsically linked. A clear understanding of the characteristics that increase the risk of acquiring these infections is vital for STI control. European evidence lists large intracountry and intercountry differences in the epidemiology of genital herpes across Europe
Methods Retrospective chart review, examining demographic, behavioural and diagnostic data of patients who attended a Cork STI clinic from 2011 to 2015 inclusive. Multivariate logistic regression models were used to study the epidemiological features of patients with a genital HSV infection (n=296) in comparison to a control group of patients with negative screen (n=307).
Results
Females (OR 3.942, P<0.001) and those aged between 25 to 30 years (OR: 8.397, P<0.001) had increased odds of acquiring genital HSV. Subjects of non-Irish ethnicity (P=0.032) and females who engaged in sexual intercourse younger than 17 years of age were more likely to present with the infection (OR: 7.427, P<0.01). Alcohol and drug use were not significant predicting factors of HSV infection. High number of sexual partners was not associated with increased risk of the infection. Consistent condom use was very low in all subjects.
Discussion Public health campaigns directed at young people, especially those engaging in sexual activity at a young age and non-Irish ethnic groups, may be beneficial. Increased distribution of condoms to at risk age groups should be considered. It is relevant to public policy design that classic risk taking behaviours were not associated with increased risk of genital HSV infection.

P214 THE USE OF ANABOLIC STEROIDS IN MALES ATTENDING A SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.256

Introduction A 2013 study by Public Health England stated 'Men who inject anabolic steroids (AS) and tanning drugs are at higher risk of HIV and viral hepatitis'. Injectors of AS are now the biggest client group at many needle and syringe programmes in the UK. The British Crime Survey on AS use among 16–59 year olds in England and Wales found in 2009/2010 0.7% had ever used and 0.2% had used in the last year. There have been no studies looking specifically at prevalence in sexual health clinic attendees and we wondered whether this might represent a different population.
Methods All male attendees to the sexual health clinic were invited to participate in the survey by self-completing an anonymous questionnaire about use of anabolic steroids, basic demographic details and details of known pre-existing blood borne virus infections.
Results 96 respondents. Age range: 3% <18, 55% 18–25, 42% >25. 82% self-identified as heterosexual. Only 1 patient admitted to having known HIV infection, none to hepatitis and 5 individuals opted not to answer this question. 4.1% admitted previous use of anabolic steroids. All were heterosexual, had injected and had used within the last year.

Discussion The use of image and performance enhancing drugs has grown substantially, but the risk of exposure to blood borne viruses among those who inject drugs to change body appearance or improve performance has rarely been studied. Although small numbers, our survey identified higher than anticipated use of injected anabolic steroids in males attending our sexual health service.

P215 SHARING THE JOURNEY; PUBLIC AND COMMISSIONER EXPERIENCES IN DEVELOPING E-SERVICE PATHWAYS IN SEXUAL HEALTH

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Introduction The London e-service is an innovative online digital health solution including: Health promotion and education; risk assessment and triage process to access self-sampling kits; provision of self-sampling kits in clinic and online; diagnostics; remote treatment for uncomplicated chlamydia; results management and partner notification.
Methods Over 5000 service users were engaged through waiting room and online surveys, interviews and public groups. There was an appetite for an online service in some segments of the population. Clinicians and commissioners worked collaboratively to develop the e-service pathway. The vision was for a high quality health pathway where the service user seamlessly travels between appropriate providers. The pathway development factored in: service user choice; clear referral pathways; protocols for safeguarding; enhanced results management and partner notification; appropriate treatment.
Results 27 boroughs participated in the collaborative procurement of the London e-service. The integration of the e-service and sexual health clinics remains a critical success factor. The pathway focuses on 2 main areas of interaction between providers: 1) The e-service 'offer' in a clinical environment; a specialist behaviour change company is working with the e-service and providers to develop channel shift resources. This is backed by a clinical service specification with associated KPIs. 2) Ensuring appropriate access to service user results and case history. This requires data sharing agreements and innovative technology solutions. The pathway was further finessed through the negotiation phase, with e-service bidders suggesting additional commercial solutions.
Discussion Can an e-service help improve access, user experience, outcomes and manage resources?

P216 EVALUATING A MOTIVATIONAL INTERVIEWING CLINIC FOR BEHAVIOUR CHANGE

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10.1136/sextrans-2017-053232.258

Introduction A service was set up to support patients in behaviour change, staffed by motivational interviewing trained nurses and workers from a voluntary drugs service.
Methods An evaluation was undertaken of the service. Between 16.09.15 and 09.11.16 at total of 101 patients were booked into the service: 53 were referred to the nurses and 48 referred to the drug worker (some were referred to both). A total of 30 patient notes were selected at random and data extracted.
Results Of the 101 patients 4 were female and 97 were male (aged 21 to 63 years old). 3 were bisexual, 5 heterosexual, the remainder MSM and 5 were sex workers. Of the 12 HIV-positive patients, all were on treatment and undetectable. In the 12-months prior to referral 15 had been diagnosed with at least 1 STI and 8 had received PEPSE (2 receiving 2 courses). Reasons for attendance; chemsex (20), substance use (7), alcohol (1) risky sexual (1) not documented (1). 19 patients had been seen within 3 attendances (range 1 to 11) and the majority did not require onward referral (n=21).
Discussion There was a high DNA rate within the service which is common among this patient type. 8 patients reduced or stopped the behaviour that they were referred for. 9 of the 15 diagnosed with an STI prior to referral did not have an STI documented in their notes post referral. This shows that MI based programmes have utility in supporting vulnerable patients desiring behaviour change.

P217 SYPHILIS ON THE RISE – IMPLEMENTATION OF ENHANCED SURVEILLANCE

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Introduction Diagnoses of infectious syphilis have risen dramatically in the UK since the late 1990s. This resurgence has been facilitated by a number of outbreaks across the UK, occurring mainly in men who have sex with men but also in heterosexual men and women.

In response, a number of enhanced surveillance initiatives have been developed and implemented across England to collect timely demographic, clinical and risk factor information. These run alongside the routine surveillance system for sexually transmitted infections, the quarterly Genitourinary Medicine Clinic Activity Dataset (GUMCADv2). The system in the East of England is described here.
Methods Up to 2016 two paper based forms were utilised. A one page 'surveillance' form was completed for every case of infectious syphilis, and a more detailed 'investigation' form used if an unusual increase required investigation. During 2016 these two forms were merged and information is now entered into an online form. All forms are completed by the diagnosing clinic.

Data collected is used to generate automatic reports, identify and investigate any unusual increases and for audits against GUMCADv2.
Results
Enhanced surveillance has allowed the identification of a number of unusual increases prompting timely and appropriate investigations to be launched; identified opportunities to improve reporting standards. The change to an online system has improved the timeliness and accuracy of reporting and made the system more secure.
Discussion Ongoing enhanced surveillance complementing GUMCADv2 is important. This information provides timely intelligence on the epidemiology of infectious syphilis across the region.

P218 SAFETXT: A RANDOMISED CONTROLLED TRIAL OF AN INTERVENTION DELIVERED BY MOBILE PHONE MESSAGING DESIGNED TO REDUCE INFECTION WITH CHLAMYDIA AND GONORRHOEA- RECRUITMENT METHODS

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Introduction Trial recruitment is one of the most important trial tasks as full recruitment provides trials with sufficient power to detect intervention effects. Yet, two thirds of randomised controlled trials fail to fully recruit. The NIHR safetxt trial is a single blind randomised controlled trial to evaluate the effect of a safer sex intervention delivered by text message on Chlamydia and Gonorrhoea infection at 12 months. 5000 people aged 16–24 are being recruited from UK GU and Sexual and Reproductive Health services. We describe the methods used to facilitate recruitment.
Methods Mixed methods informed by evidence from behavioural science including: monitoring recruitment, feedback, rewards, identifying barriers to recruitment, shared learning between recruiting clinics and staff, development of materials to address barriers to recruitment and evaluation of materials developed.
Results 34 GU and Sexual and Reproductive Health Services across the UK are involved in the recruitment endeavour. A further 13 sites are due to start recruitment. Over 1100 participants have been recruited, ahead of current recruitment targets. Telephone and face-to-face meetings with staff in recruiting services generated ideas to increase recruitment, enabled services new to trial recruitment or research nurses new to Sexual Health to learn from experienced recruiters, facilitated mutual learning and resulted in the development of materials to support staff in recruitment.
Discussion The safetxt trial is recruiting ahead of schedule. It will be a major achievement if the safetxt collaboration between GU and Sexual and Reproductive Health services and the trial management team recruit 5000 participants on time.

Sexual Health in Special Groups

P219 VACCINATING AGAINST HUMAN PAPILLOMAVIRUS IS NOT ASSOCIATED WITH RISKY SEXUAL BEHAVIOURS AMONG MEN WHO HAVE SEX WITH MEN IN AUSTRALIA

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Introduction A recent systematic review has concluded that vaccinating against human papillomavirus (HPV) does not lead to risky behaviours among females but there has been no studies examining this association among men who have sex with men (MSM). We aimed to examine the association between sexual behaviours and HPV vaccination status among men who have sex with men.
Methods We analysed MSM aged 16–40 years attending a sexual health centre in Australia for their first visit in 2016. Chi-squared test was used to examine the differences in sexual behaviours (e.g. number of male partners and condom use in last 3 and 12 months) between vaccinated and unvaccinated MSM.
Results A total of 1332 MSM were included in the analysis with a median age of 27 (IQR 23–31). Six percent (n=81) of MSM had been vaccinated against HPV. The median number of male partners in the last 3 and 12 months was 2 (IQR 1–5) and 5 (2–10), respectively. The proportion of men used condoms always in the last 3 and 12 months was 39.2% (n=797) and 36.5% (n=774), respectively. There were no significant differences in number of partners and always condom use in both last 3 and 12 months between vaccinated and unvaccinated MSM (p>0.05).
Discussion Vaccinating against HPV is not associated with increased sexual activity and condomless anal sex practice among MSM, particularly among sexually-active men attending a sexual health service.

P220 CHILD SEXUAL EXPLOITATION AND THE ASSOCIATION WITH SEXUALLY TRANSMITTED INFECTIONS IN UNDER 16 YEAR OLDS ATTENDING GENITOURINARY MEDICINE CLINICS

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Introduction Child sexual exploitation (CSE) can be difficult to identify, with few clinical symptoms or signs. There is limited evidence that markers such as sexually transmitted infections (STIs) are predictors of CSE. We present updated data and analysis from a study investigating the relationship between STI presentation at sexual health clinics (SHCs) and CSE.
Methods SHCs with >18 STI diagnoses in 13–15 year-olds in 2012 were identified using the genitourinary medicine clinic activity dataset (GUMCAD). Cases with confirmed bacterial or protozoal STIs were matched by age, gender and clinic with non-STI controls. Lead clinicians were asked to complete an online questionnaire on CSE-related risk factors irrespective of STI presence. Associations between STI outcome and CSE-related risk factors were analysed using conditional logistic regression.
Results Data was provided on 466 13-15 year-olds; 414 (88.8%) were female. 340 (80.0%) were aged 15, 108 (23.2%) 14 and 18 (3.9%) 13. In matched univariate analysis, an STI diagnosis was significantly associated with 'highly-likely/confirmed' CSE (OR 3.87, p=0.017) and safeguarding concerns (OR 1.94, p=0.022). A weak association between STI diagnosis and 'highly-likely/confirmed' CSE persisted after adjustment for partner numbers and prior clinic attendance (OR 3.85, p=0.053).
Discussion Presentation with bacterial or protozoal STIs by 13–15 year-olds at SHCs may be considered a potential marker for CSE. It would be prudent to consider CSE, in depth assessment and potential referral for any under 16 year-old presenting with an STI.

P221 SPOTTING CHILD SEXUAL EXPLOITATION (CSE) RISKS IN A SMALL RURAL COHORT; WHAT TO LOOK OUT FOR AND HOW TO EFFECTIVELY SHARE INFORMATION

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Introduction Recognition of CSE is a vital part of our work. We host a monthly multiagency safeguarding meeting (SM), alongside social services, children in care (CIC) team and hospital safeguarding. All children with high risk behaviours/vulnerabilities who have attended in the previous month are discussed including children in care, those current self-harming and those disclosing grooming or sexual assault. We will explore other factors contributing to CSE risk and demonstrate the value of the multiagency SM to care.
Methods Review of records of 90 adolescents 13-17 attending between 01/08/16 – 30/09/16. Demographics, safeguarding concerns and SM outcomes were recorded. Results were analysed using SPSS and Pearsons/Fishers tests.
Results 84% (76) were female. 13% (12) were aged ≤15. In this group a history of involuntary sex was associated with both the use of recreational drugs (p=0.002) and any diagnosis of a mental health condition (p=0.020). 12 patients were discussed at the SM. New information was shared between partner organisations in 75% (9) cases. Further results for risky behaviours can be seen in Table 1.

Abstract P221 Table 1 Spotting CSE

	Yes (%)	No (%)
History of involuntary sex	21(25.6)	61(74.4)
History of grooming	1(1.2)	82(98.8)
Sent/Received sexually explicit photos	5(8.8)	52(91.2)
Met partners on internet/social media	6(10.7)	50(89.3)
Previous or current self-harm	33(37.6)	53(62.4)
Known to Social Services	20(22.8)	68(77.2)

Discussion Discussion at the SM improves the care of vulnerable children by identifying those at risk and improving multiagency care planning. Mental health problems or illicit drug use should prompt careful evaluation for CSE risk.

P222 BISEXUAL MEN – TWICE THE FUN OR DOUBLE THE RISK?

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10.1136/sextrans-2017-053232.264

Introduction Men who have sex with men and women (MSMW) are a group with unique sexual health needs, increased risk of STI's and the potential to bridge homosexual and heterosexual populations. Information is lacking regarding sexual health behaviour among this group.
Aims Investigate STI testing behaviour of MSMW attending a sexual health clinic, recent sexual behaviour and STI diagnosis.
Methods Retrospective review of sexual health clinic electronic case notes of men attending with a new episode whose sexual orientation was recoded as bisexual from 1/4/2016 to 31/6/2016. Information was obtained on demographics, recent sexual partners, STI testing performed and diagnosis.
Results 78 MSMW attended during the audit period. Uptake of STI screening was high (95% genital Chlamydia and Gonorrhoea testing, 87% HIV and Syphilis testing). Extra genital site testing was performed in 70% patients. 79% had all appropriate sites tested according to their sexual history (oropharyngeal testing lacking in 12%, anal testing lacking in 1%, 8% unclear from documentation). In the previous 3 months 61% reported multiple sexual partners, 40% reported sex with both male and female partners and 66% reported unprotected sex with a new partner. Forty men reported a current regular female partner of which 29 also reported a recent male partner (27 unprotected). 23% were diagnosed with an STI following their clinic attendance.
Discussion MSMW showed high risk sexual behaviour and prevalence of STI's. Concordant male and female partners highlight the need to encourage regular screening in this group, record a detailed sexual history and offer all appropriate tests.

P223 IMPACT OF NATIONAL CHLAMYDIA SCREENING PROGRAMME IN CHILDREN AGED <16 YEARS ATTENDING A SEXUAL HEALTH CLINIC: 10 YEARS LATER

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Introduction The objectives of this study were to compare the rates of sexually transmitted infections (STIs) and the uptake of chlamydia test in a Level 3 sexual health clinic during pre and post National chlamydia screening programme (NCSP) periods. The programme has also included children aged <16 years if they are found to be Fraser competent.
Methods
The study period 1st September 2002 – 31st August 2016. Data were collected retrospectively from the Lilie Sexual Health Management System.
Results Total of 894 (N=894) children were studied; of whom 80% were girls. Age range was 13-15 years. Demographic details were similar in pre and post- NSCP periods.

Abstract P223 Table 1 STI and testing rates

	Overall STI rate	Chlamydia rate	Test Uptake
Pre-NSCP			
2003&2004 (n=160)	19%	6%	46%
Introduction of NSCP locally in 2004			
Post- NSCP			
2005&2006 (n=155)	23%	13%	59%
2007&2008 (n=156)	21%	15%	60%
Level 2 young people sexual health service was introduced in 2008			
2009&2010 (n=140), 5 years later	14%	7%	64%
2011&2012 (n=107)	8%	4%	66%
2013&2014(n=94)	12%	8%	66%
2015&2016 (n=82), 10 years later	9%	3%	67%

Discussion The rate of genital chlamydia infections had peaked during the immediate post- NSCP period. This is probably

related to increased uptake of chlamydia test using the less invasive method. However, the overall trend has shown some reduction in both chlamydia and other STI rates in children aged 13-15 years attending our clinic for the past eight years. The reduction might have been contributed by NSCP in addition to changes in the sexual health services locally.

P224 AGILE, DESIGN LED APPROACH TO ONLINE SERVICE DEVELOPMENT

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Introduction Sexual health services lead innovative thinking in the NHS with integrated service provision, online access and testing in non-traditional venues. Agile design-led thinking creates services that are intuitive, easy to use and valued by users (both staff and patients). It offers an alternative to pre-specifying a whole system (waterfall approach) frequently associated with unpredicted problems, identified late and requiring costly fixes.
Methods SH:24 uses an agile, design-led approach to service development delivering value by: Focusing on user need (understanding and empathising rather than assuming); Reducing cost (failing quickly, cheaply); Reducing risk (avoiding unnecessary, costly development); Creating tangible, visual, measurable outputs early (promoting understanding, collaboration and buy-in). Our agile, design-led approach included extensive user involvement; building the minimum from cycles of build, test, learn; responding to feedback, continuously improving and optimising.
Results This presentation will provide three examples describing the contribution of agile to development of:

1. Self-sampling kit instructions which delivered 76–84% return rate
2. User friendly information pages on contraception – 2000 hits daily
3. Online chlamydia treatment – 95% uptake

We will demonstrate the added value of design and agile for these examples.
Discussion An agile design led approach is championed by Government Digital Services - it involves re-framing issues as opportunities and rapidly iterating thinking by building and testing user centred prototypes - this approach minimises cost and risk while improving user experience - an approach that could add value in NHS services.

P225 DO COMMUTERS HAVE TIME FOR SAFE SEX? DELIVERING AN OUTREACH QUICK CHECK STI & CONTRACEPTION SERVICE TO LONDON COMMUTERS

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10.1136/sextrans-2017-053232.267

Introduction Sexual health services are under growing pressure to provide resource efficient STI screening and contraception services. At the same time busy people are seeking time efficient, convenient services to fit in with busy working lifestyles. By establishing an asymptomatic screening and contraception service in a well-known brand pharmacy at a busy mainline London railway station we hoped to meet both these needs.

Two weekly outreach sessions are provided by an Independent Nurse Prescriber covering both a lunchtime (12–4) and evening (4–8) session on different days. Appointments are booked online with minimal walk-in availability. Prescriptions are issued via FP10's and collected from the pharmacy.
Methods Of 1425 attendances in a one year period a retrospective case note review was done for a 3 month period July – Sept 2016 (329 attendances).
Results Of these 329 patients 75% (248) women and 25% (81) men, of whom 3 MSM. Age range 18–51 (mean age 27yrs) 51% (169) new patients, 187 asymptomatic screens done (1% positivity CT). 147 contraception issued (72% COCP, 21% POP, 5.4%, VR, 1.3% Patch), New contraception 15% (22/147), Maintain 78% (114) Change method 6.8% (10). 26 patients required EHC.
Discussion There is a high attendance and low DNA rate demonstrating this is a well-used, well positioned timely clinic to meet the needs of a busy commuter population. With more women expressing difficulty getting GP appointments for routine contraception more sessions like this would be appealing for the working population. The service is cost-efficient with low staffing and overheads.

P226 'AGENDER FOR CHANGE': REPRESENTING GENDER AND SEXUALITY DIVERSITY IN SEXUAL HEALTH

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10.1136/sextrans-2017-053232.268

Introduction Trans* identities are under-represented in UK sexual health data. One possible reason is that the traditional representation of gender within the restricted binaries of male and female contributes to the low numbers seen in sexual health services. We aimed to obtain a clearer understanding of the hidden gender and sexuality identities accessing an LGBT-targeted sexual health service.
Methods We offered full sexual health screening in a community LGBT clinic during National HIV Testing Week in 2016. A self-completed triage form was used to register patients. Additional gender identity options were added to the form. This included an 'other' box with an option to specify any gender or sexual identities that had not been represented on the form.
Results 78 patients completed the registration form. 52 identified as male and 18 female. 8 (10%) described different gender identities; 2 trans*-men, 2 demi-boys, 1 gender fluid, 1 bi-gender and 2 non-binary.

In terms of sexual orientation, 8 identified as heterosexual men, 50 as gay men, 2 as lesbian women, and 6 (2 male, 3 female and 1 non-binary) as bisexual. 11 identified themselves as pansexual and 1 (a demi-boy) as asexual.
Discussion Increasing the options during registration captured a wide variation in reported gender identity and sexual orientation. To avoid a complex, multi-option question on the registration form, we would suggest that simplifying this to 'please describe your gender' and 'please describe your sexuality' would be advantageous for both the patient and health care professional.

P227 FACTORS ASSOCIATED WITH SEXUALLY TRANSMITTED INFECTIONS IN <16'S ATTENDING A GUM CLINIC

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Introduction We established whether number of sexual partners and vulnerability factors were associated with sexually transmitted infections (STIs) in <16 year olds.
Methods Data was captured on <16's attending a GUM clinic 01/01/15–31/12/15, using a standardised electronic proforma. Data collected: Demographics, appointment type, postcode, STIs, pregnancy, contraception, number of sexual partners and vulnerability factors (mental health, drug use, history of abuse, known to outside agencies, gang involvement).
Results 236 attendances by 124 patients; 89/124 (72%) new, 35/124 (28%) rebook. 50/124 (40%) <16s resident in GUM clinic borough, 59/124 (48%) from neighbouring boroughs. 107/124 (86%) female. Ethnicity: 54/124 (43%) White British, 32/124 (30%) Caribbean, 15/124 (12%) African. Median age at first attendance 14.6 years (range 12–15). 447/88 (53%) patients using contraception and 23/107 (21%) females had pregnancy test; 2/23 (8.7%) positive. 31/124 (25%) were diagnosed with or were contact of an STI (Chlamydia n=22, Gonorrhoea n=5, PID n=2, HSV n=2, HIV n-1), of whom 9/31 (29%) reported $\geq$ one vulnerability factor. Average number of sexual partners in this group was 3.45 (Range 0–15). 93/124 (75%) were not diagnosed with an STI, of whom 27/93 (29%) reported $\geq$ one vulnerability factor. Average number of sexual partners was 1.75 (Range 0–20).
Discussion 29% of patients (36/124) attending the clinic had $\geq$ one vulnerability factor. <16s diagnosed with an STI were not significantly more likely to have a vulnerability factor than those who were not. However, those diagnosed with an STI had a greater number of sexual partners than those without a diagnosis.

P228 SEXUAL & REPRODUCTIVE HEALTHCARE OUTCOMES AMONG THOSE AT RISK OF CHILD SEXUAL EXPLOITATION: A RETROSPECTIVE REVIEW

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Introduction The purpose of Multi-Agency Sexual Exploitation (MASE) panels is to consider cases of high risk victims and offenders in relation to Child Sexual Exploitation (CSE) and the criminal justice response to offenders. A multiagency approach should ensure young people (YP) are supported by appropriate services including SRH.
Methods A retrospective review of a selection of MASE cohorts from 2016 from three services across England was undertaken. The names of YP were cross-referenced with the SRH clinic system in the locality to determine if they had accessed the service. Information was collected on reason for attendance, sexual health screening, contraception and gravidity. Data was analysed using Excel.
Results Of 92 young people discussed at MASE panel, 64 (69.6%) were known to SRH services. The age range was 12–19 years (median 16). Sixty (93.7%) were female. The most common reasons for attendance were request for contraception (35.9%), pregnancy testing (25%) and disclosure of sexual assault (10.9%).

19 (29.7%) individuals had tested positive for chlamydia on at least one occasion (25 episodes in total). Fourteen pregnancies were reported with 8 resulting in termination.
Discussion Rates of chlamydial infection and pregnancy were high among the MASE cohorts reviewed. The multi-agency response should provide an opportunity to address health needs of this vulnerable group. Interventions should be targeted accordingly including prioritising referral into SRH services into the care plans of those identified to be at risk of CSE.

P229 HSV MANAGEMENT IN PREGNANCY AT A JOINT ANTENATAL-GENITOURINARY CLINIC IN A LARGE MATERNITY HOSPITAL IN DUBLIN, IRELAND – A MODEL OF CARE

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Introduction The ultimate goal of HSV management in pregnancy is to prevent perinatal transmission and, where possible, to facilitate vaginal delivery.
Methods Data was collected from antenatal charts of 107 women who reported a history of HSV or who had a documented outbreak during that pregnancy. Descriptive column statistics were used in excel for data analysis.
Results From May 2013 to Feb 2017, 107 Women were seen in the clinic for management of HSV in 108 pregnancies. Median gestation at referral (82/108) was 23/40 (range 2–39/40). Mean age 33yr (range 18–45). 91 (85%) European. 9 (8%) HIV+. 82 (76%) reported prior history. 96 (89%) had type-specific serology sent of which 89 (92%) HSV IgG +ve. 28 (31%) HSV 1 & 2 positive, 47 (52%) Type I positive only, 12 (13%) Type 2 positive only, 2 were weak + and not typed. 69 (63%) had STI testing, 100% negative. 4 of the 107 (80%) had primary HSV in that pregnancy. 67 received HSV prophylaxis; 66 valaciclovir; 1 aciclovir. Mean gestation starting prophylaxis was 36/40 (range 20 – 39). Data on mode of delivery on 82 of 107 (76%) pregnancies; 59 (71%) vaginal, 24 (29%) lower segment caesarean sections, none for HSV. Median gestation at delivery of 84 pregnancies 39/40 (range 29 – 41). To date no cases of perinatal HSV transmission have been reported.
Discussion There is good compliance with Irish guidelines on HSV management in pregnancy. HSV2 remains an issue. This combined clinic facilitates good compliance with standard guidelines for HSV management in pregnancy. This model of care should be available across all antenatal settings.

P230 SEXUAL HEALTH WORKERS ARE AT HIGHER RISK OF POOR SEXUAL HEALTH: A PILOT STUDY

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10.1136/sextrans-2017-053232.272

Introduction The effects of occupation on personal heath have been described, but there is a paucity of literature on how working in sexual health affects an individual's sexual behaviour.
Methods We gained informed consent from a focus group of 6 female and 2 male sexual health workers in 2010. The focus group was tape recorded, anonymised and transcribed. We used thematic analysis to generate themes.
Results Sexual health workers feel confident in making an assessment of their own sexual behaviour; yet acknowledge that this self-assessment is not consistently reliable. Access to medication (including antibiotics and emergency contraception) leads to an increase in sexual risk taking in this group. Self-medication occurs for unplanned risks rather than pre-planned. There is reluctance on the part of sexual health workers to consult colleagues due to concerns about lack of anonymity, confidentiality and how positive results will be managed. Sexual health workers feel that these behaviours are a barrier to good sexual health. They also feel that both patients and sexual partners expect them to be more sexually experienced; this can lead to discord in personal relationships. Sexual health workers feel that due to the nature of their work, they have a greater and more realistic insight into sexual relationships; in particular monogamy. They also have greater confidence in their ability to discuss sex with their children and families.
Discussion This pilot study suggests that sexual health workers may be at risk of poor sexual health and have specific sexual health needs not currently addressed.

P231 UNDERSTANDING SEXUAL PRACTICES, ATTITUDES AND SEXUAL HEALTH SERVICE PROVISION IN THE OVER 50S

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10.1136/sextrans-2017-053232.273

Introduction Since 2011 STI incidence has increased in the over-50 population in the UK.

Higher divorce rates, lack of awareness, poor service provision and low pregnancy risk have all been suggested as contributing to these changes.

We examined sexual practices and attitudes of >50s in our city centre clinic, and assessed service accessibility.
Methods Anonymous questionnaires distributed opportunistically to 50 attendees (23 male 27 female), examining sexual practices, STI awareness and attitudes towards service provision.
Results Almost half had divorced previously. 50% men never used condoms, 67% women; reasons given included 'married', 'no pregnancy risk', 'too old', 'don't like it'. 60% used at least one regular medication and 10% were using >6 drugs. 37% of women and 20% of men were 'too embarrassed' to discuss sex with GP. 44% women, 26% men were first-time attenders. All the women in our sample were white heterosexual. There was more ethnic diversity in men, and 30% MSM. There was good awareness of STIs and safer sex, and 70% felt that current services met their needs.
Discussion Reassuringly, many were attending for the first time suggesting ease of access. However, a lack of diversity in female attendees may indicate unmet needs in some groups. Despite being aware of good sexual health, there was low condom use and a lingering embarrassment to discuss problems with family doctor. This survey suggests unmet needs still exist, even in those who already access services. A similar project in primary care is planned to further assess this.

P232 SOMEWHERE OVER THE RAINBOW: ESTABLISHING ACCEPTABLE LOCATIONS FOR STI SCREENING AND SUPPORT FOR MSM

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10.1136/sextrans-2017-053232.274

Introduction Over the Rainbow is a community based LGBT support service and level 3 GUM clinic in Bournemouth, currently under threat due to funding cuts. In May 2016, a patient consultation was undertaken to explore alternative options for service provision.
Methods A survey was distributed online and in clinic to capture views on the provision of local sexual health services for MSM.
Results 96 people responded to the survey after visiting the service for STI screening (60%) or one to one support (40%). 40% of these would not be happy attending a mainstream GUM or CASH clinic, or GP for STI screening. 34% would not be happy to access STI screening on-line. One third would be unwilling to attend alternative agencies for counselling or support.

80% of the 86 online respondents had attended Over the Rainbow in the past. Responses indicated that even fewer (44-56%) would be happy to attend a mainstream GUM or CASH clinic or GP for STI screening, with a similar proportion reluctant to attend other community settings.

Comments highlighted that service users valued a dedicated LGBT service, in the heart of the gay community. It was described as a safe haven.
Discussion Future service design and provision must consider community need. Patients expressed a preference for LGBT specific community based services, able to accommodate their sexual health needs within a holistic framework. Many value a face-to-face consultation rather than accessing STI screening on-line.

P233 SEXUAL DYSFUNCTION: PRIMARY, SECONDARY OR A BY-PRODUCT OF SECRET ISSUES?

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10.1136/sextrans-2017-053232.275

Introduction To explore the referral diagnosis of sexual dysfunction from a psychosexual basis.
Methods A retrospective analysis of 50 women who were referred to a clinical sexologist for varying aspects of sexual dysfunction during January 2016 – December 2016.
Results Although 100% of women exhibited a variety of sexual dysfunction, 44% displayed variables of sexual abstinence due to real and perceived problems that directly impacted on their ability to participate in sexual intimacy. Factors not explored or discussed by the referring Health Care Professional (HCP) included urinary incontinence, religious/spiritual beliefs, perception of guilt relating to previous sexual behaviours and ill health of the partner.

Discussion Sexual Dysfunction referrals encompass a broad range of issues. These fall into sub-categories being further classified as primary and secondary. It is identified that a reasonable proportion is still incorrectly identified by the HCP, missing the underlying true reason for sexual abstinence. The ability to ask/frame questions within the assessment is significant to unlocking the contributing or causal problem. Incorporating specific questions assists in decreasing/removing any sense of guilt the woman may have around this.

P234 STI TESTING IN HIV POSITIVE MSM PATIENTS: A MISSED OPPORTUNITY?

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Introduction Approximately 1 in 20 men that have sex with men (MSM) are infected with HIV. The risk of acquiring a sexually transmitted infection (STI) is higher in this population compared with heterosexuals. Therefore, it is important for HIV positive MSMs to have regular sexual health screening to reduce the risk of transmission of STIs and HIV.

Consequently, the British HIV Association recommends that HIV positive MSMs should have annual STI screening. Furthermore, those that are classified as high-risk should be tested every 3 months.

Methods This audit retrospectively gathered case notes of HIV positive MSMs that have been seen in the last 12 months, October 2015 to November 2016. The following criteria were assessed: annual or 3 monthly screening of STIs, hepatitis B and C immunity status, patient age, evidence of high-risk behaviours and year of HIV diagnosis. The criteria for high-risk behaviour included: multiple partners (>2 in the last 12 months) and drug use. The data will be used to assess what proportion of patients are screened in line with national guidelines and to identify ways the practice can increase the uptake of screening.

Results The results show that 84% of cases were not screened annually for hepatitis C and 40% of patients were not receiving the minimum screening for STIs. However, 78% of patients were vaccinated against hepatitis B.

Discussion In conclusion, this audit shows that there is a failure to meet the minimum level of screening for this high-risk group. We aim to improve this via a new pro-forma and education.

P235 AN AUDIT OF THE CARE OF MSM ATTENDING AN OUTER LONDON INTEGRATED SEXUAL HEALTH SERVICE

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Introduction Men who have sex with men (MSM) remain a high risk group for HIV infection, increased rates of syphilis, LGV and gonorrhoea indicating high levels of risky sexual behaviour. The aim of this audit was to measure care against BASHH recommendations for testing for STIs in MSM (2014) and local guidelines to ensure high quality accessible services for MSM.

Methods Data were collected retrospectively from electronic patient records of all MSM first attendances across all clinics between 1 January 2015 to 30 June 2015 (N=96) and data analysed using SPSS and Excel.

Results 79% (76/96) of MSM were from our local borough; age range was 16–65 with highest attendance in the 25–29 years age group; 43% were from BME communities. 100% were offered STI screening, 91% accepted (87/96) and 47% had a STI diagnosed. 80% of MSM had a comprehensive assessment undertaken while 65% had a record of vaccination status. PEPSE discussion was recorded for 76% of eligible patients. 100% of suitable patients were offered HIV testing (n=88/96), 90% (79/88) tested with a positivity rate of 2.5% (2/79).

Discussion The service is highly accessible to local MSM, STI testing offer exceeded the BASHH recommendation of 97% and uptake of 91% exceeded the BASHH recommendation of 80%. Uptake of HIV testing met the BASHH recommendation of 90% but improvements are needed in PEPSE and PREP discussions and determining Hepatitis B status in all eligible clients. EPR has been revised and staff training undertaken to address and improve on this.

P236 AWARENESS AND RESOURCES FOR INDIVIDUALS WHO ARE TRANSGENDER WITH AUTISTIC SPECTRUM DISORDER- A HEALTHCARE PROFESSIONAL'S PERSPECTIVE

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10.1136/sextrans-2017-053232.278

Introduction Autistic Spectrum Disorder (ASD) affected around 1% of the general population but has been reported in 7.8% of childhood gender identity clinic referrals. Gender identity is an increasing healthcare focus; the United Kingdom's only childhood gender identity clinic witnessed a 930% increase in referrals in six years, with Sussex having the highest adult service referral rates. This study aims to assess healthcare professionals' awareness of a co-occurrence between ASD and transgender, identify resources and determine how these could be improved, based on the needs and concerns of individuals.

Methods A service evaluation of healthcare professionals who frequently see individuals about ASD and/or gender identity was conducted in Brighton. An anonymised online questionnaire, created using Survey Monkey, was accessible from January 2017 until March 2017. Participants were contacted via NHS emailing lists with explanatory information and a survey link. Quantitative data was collated as raw data and percentages. Qualitative data was organised into tables and key themes identified.

Results Limited evidence suggests that healthcare professionals were unaware of an association between ASD and transgender and most were unsure if resources existed. Most felt that training would improve care, with a particular focus on local and online resources, referral pathways and current research evidence. Mental health issues, family concerns about gender identity interventions, not being accepted and vulnerability were major concerns.

Discussion Co-occurring ASD and transgender is under-recognised by healthcare professionals. Future resources should

focus on the specific needs and concerns of these individuals and aim to raise awareness.

P237 ARE THE OVER 50S BEING LET DOWN BY SEXUAL HEALTH CLINICS? – AN AUDIT OF SEXUAL HISTORY TAKING IN OVER 50S

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10.1136/sextrans-2017-053232.279

Introduction Ageing and Human Immunodeficiency Virus (HIV) has been very topical for a long time but not much has been said of ageing and sexually transmitted infections (STI). The Public Health England STI 2015 update indicates there has been an increase in the rate of STIs in the over 45s since 2011.
Methods 50 random case notes of patients over 50, seen between April 2015 and March 2016 in Sefton Sexual Health Clinic, Southport, North West England. These cases were audited against the 97% target in Sexual History taking 2013 guidelines.
Results There were 31 men (62%), 4 of whom were homosexual, and 19 (38%) women, all heterosexual. Patients were aged between 50 to 75 years old. 78% were symptomatic. 16% had casual partners, 38% of these used commercial sex workers. 44% were asked about previous STIs and 60% of patients were offered STI screening and off these 13% declined. 82% of patients were asked if they had ever had an HIV test and of these 44% had. Of the 56% that said they had never had a test, 100% were offered a test and 87% accepted. The commonest diagnosis was the first episode of herpes and herpes reoccurrence (both 12%), then first episode of warts (10%) and wart reoccurrence (8%). No patients tested positive for Chlamydia or Gonorrhoea.
Discussion STI and BBV screening at any age should be guided by an accurate sexual health history and not an assumption. It is a disservice to simply assume low risk due to age.

P238 WORKING THE STREETS – TARGETTING MIGRANT SEX-WORKERS THROUGH DEDICATED OUTREACH

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10.1136/sextrans-2017-053232.280

Introduction Sex-workers do not always engage with traditional healthcare settings and migrant sex-workers are a growing vulnerable group. Our city uses a 'managed approach' to sex-working, with focus on identifying exploitation and trafficking. This gives a unique opportunity for outreach.
Aim(s)/objectives Provide accessible sexual healthcare, health promotion and contraception to sex-workers not accessing care. Evaluate this outreach service after one year.
Methods A partnership was established between the Integrated Sexual Health service and a local Third Sector Sex-work Project. Sex-workers were offered STI testing, treatment, HepB vaccination and contraception in an outreach setting (own homes/workplaces, charity premises, streets).

Results (at one year):

129 sex-workers seen (289 contacts); 70/129 (55%) were migrant (majority Romanian), 113 contacts; 70% previously unknown to sexual health services. Contraception was extended over the first year and provided to 25 sex-workers; Hep B vaccination offered to all. 45 infections identified in 28/70 (40%) migrants (compared with 26 infections in 21/59 (36%) non-migrant sex-workers): 33/45 Chlamydia: 20 extragenital (5 pharyngeal, 15 rectal); 5/45 Gonorrhoea (all extragenital); 8/45 Trichomonas Vaginalis. 27/28 successfully treated (1 moved away). 4 women had re-infection on interval rescreening (all Chlamydia). 1 case of chronic HepB, 1 chronic HepC, no cases HIV or syphilis
Discussion This new outreach service successfully targeted a vulnerable group with a disproportionately high STI burden (40%). Use of a dedicated outreach team achieved trusted relationships with sex-workers. Secondary benefits included a 250% increase in women identifying as sex-workers accessing mainstream clinics.

P239 RETURNING SEXUALLY TRANSMITTED INFECTION RESULTS TO ADOLESCENTS: A REVIEW OF THE LITERATURE

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10.1136/sextrans-2017-053232.281

Introduction Sexually Transmitted Infections (STIs) are an important cause of poor reproductive and sexual health in adolescents. Prompt diagnosis and treatment are key to reducing long term sequelae. We reviewed the evidence on current methods of results delivery for STIs, with a focus on adolescent services.
Method The literature was reviewed systematically between June and August 2016. Six databases were searched, reference lists reviewed and authors contacted for studies on methods of results delivery for STIs to adolescents (aged 15–25 years). Titles and abstracts were reviewed and full text obtained for quality assessment and data extraction.
Results Of 549 studies identified, 19 fulfilled the inclusion criteria. Seven studies focused on adolescent populations, all in high-income settings. Three studies in low- and middle-income settings and nine included adolescents as a stratified group. Twelve studies were cross-sectional, two randomised control trials, the remaining employed mixed methods. Outcome measures varied widely, percentage preferences for method of results being the commonest measure. Findings show that mobile phone call and text were the commonest methods of returning results. Other modalities including text message, email and online notification demonstrated wide variations in acceptability. Preferences varied according to type of result, population type, location, client group and previous service use. Mobile phone calls and face-to-face consultations remain highly acceptable.
Discussion The use of mHealth offers promising options for STI results delivery. Methods adopted must consider the target population accounting for gender, age, ethnicity and access to technologies. Customisation is recommended to meet user requirements for optimal health care delivery.

Viral Sexually Transmitted Infections

P240 WHAT ARE THE VACCINATION NEEDS OF MSM IN THE CURRENT HEPATITIS A VIRUS (HAV) OUTBREAK? A RETROSPECTIVE STUDY OF THE HAV IMMUNE STATUS IN FIRST-ATTENDANCE MSM IN A LONDON GUM CLINIC

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10.1136/sextrans-2017-053232.282

Introduction Hepatitis A infection in MSM increased in incidence from late 2016 in the UK and has reached outbreak status. By February 2017, 42 confirmed or suspected cases had been reported in London. BASHH hepatitis guidelines recommend HAV vaccination of MSM in outbreak situations.
Methods We looked at 100 consecutive MSM who attended our service for the first time in early 2016 to assess what the vaccination needs of MSM would be.
Results Sixty seven of these MSM had a baseline HAV total antibody test of which 33 (49%) were HAV-Ab positive. A further 5/66 (8%) MSM gave a history of HAV vaccination but were antibody negative. 16/33 (48%) HAV-immune MSM gave a history of previous vaccination. 7/66 (11%) of the MSM who were immune, but non-vaccinated, came from HAV-endemic countries and presumed naturally immune.

49/98 (50%) who had baseline HBV antibody levels were HBV-immune of whom 14/49 (29%) were also HAV immune.

Extrapolating from these data, our estimates for baseline vaccination requirements in new MSM were: 28% require monovalent HAV vaccine, 24% require monovalent HBV vaccine, 21% require bivalent HAV/HBV vaccine and 27% require no vaccine.
Discussion If these data are representative of MSM in London, 49% (57% including those vaccinated but HAV-Ab –ve) are already HAV-immune. This has implications with regards to estimating the pool of non-immune MSM at-risk. It also enables us to estimate the types of vaccine required to meet the MSM's needs in relation to HAV as well as HBV in the current outbreak

P241 WHERE THERE'S TEA, THERE'S HOPE! – EXPERIENCE OF GREEN TEA EXTRACT FOR TREATMENT OF GENITAL WARTS

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10.1136/sextrans-2017-053232.283

Introduction Catephen® 10% ointment is novel extract from green tea which is licenced for genital wart treatment and included in BASHH guidelines (2015). Recommended application is 3 times daily for 16 weeks. We present real life data of Catephen® experience.
Methods Review of patients treated with Catephen® and adjuvant cryotherapy between August 2016 – February 2017. Clinical outcomes and tolerability data were collected.
Results 33 patients identified, median age 26 years (32 male, 1 female). 2 HIV positive. Affected site; penis 23/33, perianal 7/33, both 2/33 and vulva 1/33. All cases were recurrences. 6 patients excluded as lost to follow-up. To date 17/28 have completed 16-week course Catephen® or achieved full clearance prior to this. Outcomes are still awaited for 2/27 patients and 8/27 discontinued treatment early. Of the 17 who have completed treatment, 11(65%) had total clearance and 6(35%) partial clearance. Mean time to clearance was 8 weeks with penile warts appearing to respond better than perianal. Catephen® was well tolerated with 43% stating they had fewer side effects than with previous treatments. Overall discontinuation rate was 8/27 (30%) with 1 report of vulval pain, 1 report of stained clothing and 6 reporting unsatisfactory response (mean duration of Catephen® use 6.5 weeks). An additional 3 patients reported skin discomfort but continued treatment.
Discussion Catephen® ointment appears well tolerated with satisfactory clearance rates. It appears to be an acceptable alternative to other topical treatments for genital warts. To date there is no trial data on continued use after 16 weeks.

P242 LASER ABLATION TREATMENT FOR COMPLEX HPV-RELATED DISEASE IN A GUM CLINIC SETTING

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10.1136/sextrans-2017-053232.284

Introduction GUM specialist services to treat complex HPV-related diseases unresponsive to conventional therapies are limited. Laser vaporisation following local anaesthesia is an established treatment for refractory warts and intraepithelial neoplasia. Several service specifications have called for these treatments to be delivered and funded outside of Level 3 GUM clinics. A specialist Laser Clinic was established within our centre in 2015. A specially trained clinician reviews individuals. Where the diagnosis is unclear, biopsies are performed. CO2 laser vaporisation is instituted following application of local anaesthesia. Post-operative pain relief is provided and attendees are asked to follow a post-laser pain control algorithm. All attendees are asked to complete a feedback form.
Methods The case notes and patient feedback of all attendees to the Laser Clinic were reviewed.
Results 155 unique patients have been seen since January 2015. 134 laser procedures have been performed with no evidence of recurrence or reinfection. Diagnosed cases of anogenital intraepithelial neoplasia: PIN: 14, AIN: 24, VIN: 7 (45/134).

100% of attendees rated the service as excellent or good, with 95% stating that their pain was controlled throughout the procedure.
Discussion 30% of attendees were found to have intraepithelial neoplasia. Encouraging patient feedback, high rates of pathology and positive post-operative outcomes with no evidence of recurrence demonstrate that laser therapy is a valuable treatment option, avoiding the need for onward referral, general anaesthetic and more costly procedures outside of the

GUM setting. This service illustrates the importance of maintaining complex service delivery within the GUM setting.

P243 COULD THE CURRENT OUTBREAK OF HEPATITIS A IN MEN WHO HAVE SEX WITH MEN IN LONDON HAVE BEEN PREDICTED OR PREVENTED?

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10.1136/sextrans-2017-053232.285

Introduction The current outbreak of Hepatitis A and the recent Shigella outbreak in men who have sex with men (MSM) highlight the importance of faeco-orally transmitted organisms in this population. This may suggest that outbreaks could be predicted or prevented.
Methods We compared the age, sex and travel history of notifications of Hepatitis A with notifications of Shigella in South London between January 2010 and November 2016. We also reviewed documentation of previous outbreaks of Hepatitis A in MSM in London.
Results Male and female cases of Hepatitis A had similar age profiles and a similar proportion reported recent travel. In contrast, Shigella cases peaked in males aged 30–39 with no travel history. Case notes for Hepatitis A notifications since January 2013 suggested fewer than five in MSM. Although this review suggested very few cases in recent years, outbreaks of Hepatitis A among MSM in London were documented in the late 1990s and in 2003. The second outbreak was associated with strains that caused concurrent outbreaks in MSM across Europe. Public health response to these outbreaks recommended health promotion and opportunistic immunisation.
Discussion Hepatitis A outbreaks occur sporadically in a transnational population of MSM. Few cases may occur between outbreaks and preventative actions may be deprioritised. However, group immunity is likely to be highest after an outbreak and then wane in the absence of immunisation, increasing the risk of another outbreak. Health promotion and immunisation may be valuable outside of outbreak contexts.

P244 AN AUDIT OF HEPATITIS C TESTING IN A SEXUAL HEALTH SERVICE

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10.1136/sextrans-2017-053232.286

Introduction With new effective treatments for hepatitis C (HCV), identifying cases is increasingly important. The BASHH Viral Hepatitis Guidelines (2015) recommend HCV screening in sexual health services for people at high-risk. We carried out a retrospective audit in our clinic.
Methods We reviewed our patient records and laboratory database for HCV antibody (AB) tests between 1st January 2015 – 30th June 2016. The management of those HCV RNA positive was compared with the BASHH auditable standards (2015).
Results From 56483 attendances, 12008 HCV AB tests were taken. 18/12008 cases were HCV AB positive of which 11 were also HCV RNA positive giving a prevalence of 0.09%. 8/11 newly diagnosed; 6/11 male; 6/11 Eastern European, 3 White British, 2 Asian; 4 co-infected with HIV. Genotypes were available for 6/11 and of these 4 had G1a, 1 had G1b and 1 had G3a. 11/11 had LFTs/AFP (target 90%) and all had hepatitis B tests (target >95%). 11/11 were referred for ongoing care within 2 months (target 100%). All had a written follow up plan (target 97%) and all had a documented discussion regarding the natural history and transmission of HCV, but only 2 (18%) had documentation that written information was also given (target >95%). All had partner notification (target 97%).
Discussion The prevalence of HCV infection in our screened population was lower than we expected (0.09%) for an area with a large migrant population. Our service met all auditable standards in management except for documenting that written information had been given.

P245 MONITORING THE UPTAKE AND EARLY IMPACT OF TARGETED HPV VACCINATION AMONG MEN WHO HAVE SEX WITH MEN (MSM) ATTENDING GUM AND HIV CLINICS IN ENGLAND

[1]Marta Checchi*, [1]David Mesher, [1]Mark McCall, [1]Cuong Chau, [2]Kavita Panwar, [2]Simon Beddows, [1]Kate Soldan. *[1]HIV/STI Department, Centre for Infectious Disease Surveillance and Control, National Infection Service, Public Health England, London, UK; [2]Virus Reference Department, Microbiological Services, National Infection Service, Public Health England, London, UK*

10.1136/sextrans-2017-053232.287

Introduction MSM are at high risk for HPV infection and associated disease (genital warts and anal, oropharyngeal, and penile cancers). Additionally, MSM will receive little or no herd protection from the existing national vaccination programme for females. Following Joint Committee on Vaccination and Immunisation (JCVI) advice, a targeted HPV MSM vaccination pilot was introduced in GUM and HIV clinics across England from June 2016. We present plans for monitoring vaccination uptake and surveillance of infection and early disease outcomes.
Methods Uptake (of three doses over a two year period) will be monitored via two existing surveillance and reporting systems: the Genitourinary medicine clinic activity dataset (GUMCADv2) and the HIV and AIDS reporting system (HARS). A seroprevalence study conducted in selected clinics for validation of these data will be considered in due course.

Early impact of targeted HPV vaccination of MSM on the epidemiology of HPV infection will be detected by HPV DNA testing of rectal swabs (residual specimens following chlamydia testing) from MSM attending selected GUM clinics, starting with largely baseline collection in 2017.

Expected early effects on genital warts diagnoses will be monitored (via GUMCADv2). A decline in HPV-associated cancers is not expected to be seen for some years.
Discussion A comprehensive surveillance strategy has been established to evaluate targeted HPV vaccination of MSM at GUM/HIV clinics. During the pilot, uptake will be the main outcome measure available, and surveillance systems will be established and baseline data collected to evaluate the outcomes of national implementation on infection and disease.

P246 AN AUDIT OF THE DIAGNOSIS AND THE MANAGEMENT OF GENITAL HERPES IN AN INTEGRATED SEXUAL AND REPRODUCTIVE HEALTH SERVICE

Johanna Heanue*, Vinod Kumar. *St. Peter's Sexual Health Clinic, Leicester, UK*

10.1136/sextrans-2017-053232.288

Introduction The psychological impact of genital herpes simplex virus (GHSV) can be significant but appropriate antiviral therapy and counselling can reduce anxiety and improve quality of life during recurrences. We evaluated the management of GHSV in our integrated sexual health clinics.
Methods Retrospective case notes audit of patients who were clinically diagnosed with first episode of GHSV, or managed with suppressive therapy for recurrent herpes, between March 2016 and May 2016. The case notes were identified from GUMCADv2 dataset (code C10a/C10b). The data were collected using a standard audit record sheet, developed using BASHH guidelines.
Results Of 103, 58% were female. The median age was 26 years (range 16 – 59 yrs). A HSV PCR swab was obtained in all patients presenting with a first episode of GHSV (n = 73). Type 1 and Type 2 HSV were typed in 52% and 38% of cases respectively. Syphilis testing was offered to 84% patients. Aciclovir was given to 85% patients. Verbal information giving was good (78%), whereas provision of written information was poor (19%). In patients (n=30), who were managed with suppressive therapy for recurrences, Type 2 HSV was typed in 83% cases. A reason for commencing suppressive therapy was recorded in 77% cases. A clear plan regarding duration of suppressive treatment and follow-ups were recorded 23% and 67% cases respectively.
Discussion This audit demonstrated many areas of good practice but also identified potential gaps between national recommendations and current clinical practice. Recommendations are made to reach the standards set by BASSH.

P247 AN AUDIT OF HEPATITIS B AND C TESTING IN A SEXUAL HEALTH SERVICE – AN OPPORTUNITY FOR COST SAVING

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10.1136/sextrans-2017-053232.289

Introduction BASHH have recently updated guidelines as regards criteria for hepatitis B and C testing. Are patients accessing the service offered hepatitis B and C testing appropriately? Furthermore can this data be extrapolated to calculate potential cost reductions should audit data suggest overtesting.
Methods 100 case notes SHHAPT coded as T6 from 2 local clinics were scrutinised as to whether testing followed BASHH guidelines. In addition 50 case notes were randomly selected to ascertain whether a T6 code should have been applied.
Results 87/100 (87%) underwent hepatitis B testing of which 10/87(11%) were found to be inappropriate The reasons for testing in this 11% included sexual exposure in a low prevalence (mostly in Europe), saliva exposure, and a history of an ex-partner with multiple contacts – 38/100 underwent hepatitis C testing of which 14/38 (36%) were tested inappropriately—the reasons given included contact with men having sex with men(MSM) with no history of chemsex, contact with a HIV infected patient, sexual assault, sexual contact with an intravenous drug user and sexual exposure in Europe. In the audit of random selection of 50 casenotes- there were no cases of missed opportunities for hepatitis testing. Extrapolation of data showed that £1739 annually could be saved if all testing for hepatitis B and C was based on national guidance.
Discussion Given the proven overtesting in the audit, guidelines are to be reiterated to clinical staff. It is hoped that this would translate to costs savings on an overstretched service pathology budget.

P248 GENITAL WARTS AND TREATMENT OPTIONS: CLINICAL AUDIT

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10.1136/sextrans-2017-053232.290

Introduction Genital warts are a common presenting condition in sexual health clinics. There are different treatment options available within BASHH guidelines depending on the size and location of warts. Home treatment reduces follow up clinic attendance.
Method We randomly selected 30 patients attending our integrated sexual health service with new genital warts and audited their management against local guidance that home treatment with Imiquimod should be used first line for 4 weeks, unless contraindicated.
Results Of the 30 patients, 18 were male and 12 were female. 14/30 were prescribed Imiquimod only. 7 patients had Cryotherapy only and 9 were also given cryotherapy before Imiquimod. 9/11 who received cryotherapy requested this treatment. 6/11 had documented reasons why it was deemed appropriate to have cryotherapy (unable to apply cream themselves, site of lesion). Interestingly, all 9/9(100%) who had received combination treatment reported clinical resolution within 4 weeks. 6/7(86%) who had cryotherapy only clinically resolved after 3 consecutive applications. 11/14(79%) treated with Imiquimod only resolved within 4 weeks, one deferred. 11/19(58%) treated with Imiquimod experienced side effects and five patients (5/11) sought medical advice. There were no reported complications following cryotherapy application.
Discussion Despite imiquimod being the recommended first line initial treatment for genital warts in our service, some patients received cryotherapy treatment in isolation or a combination of imiquimod and cryotherapy. The patients receiving cryotherapy were likely to have requested this treatment and had less side effects. All patients who received imiquimod and cryotherapy had resolution of genital warts in four weeks.

P249 AUDIT OF ADHERENCE TO REFERRAL PATHWAY FOR PREGNANT WOMEN WITH HISTORY OF GENITAL HERPES BOOKED AT A TERTIARY REFERRAL MATERNITY HOSPITAL, AUG 2015 – AUG 2016

Orla Cunningham*, Nikita Deegan, Michael O'Connell. *CWIUH, Dublin, Ireland*

10.1136/sextrans-2017-053232.291

Introduction Genital Herpes Simplex Virus (HSV) can be transmitted in the perinatal period with the potential for

serious and devastating consequences for the fetus/infant. Transmission from mother to infant most commonly occurs due to exposure during delivery (85 – 90%). Early 2014, the team caring for women with Infectious Diseases in pregnancy identified that women, with a history of genital HSV or an outbreak in pregnancy, were an at-risk group without a specific care pathway, often with differing clinical decisions regarding their care.

Methods A retrospective audit was undertaken to ascertain adherence to a newly introduced referral pathway for pregnant women who gave a history of genital herpes booking into a tertiary referral Maternity Hospital, August 2015 – August 2016.

Results Our initial audit over a 9 month period demonstrated that there was an overall deficit in knowledge regarding the new referral pathway. The 9 month audit showed that only 13 of 49 (26%) of women were referred to specialist services at any time during their pregnancy. Our subsequent audit showed 54% of women were referred for specialist consult in the period following re-education; a large improvement in awareness of our referral pathway.

Discussion Audit of practice and in particular following an introduction of a new care pathway, is an essential tool for demonstrating compliance as well as highlighting gaps which require addressing. Education targeting the team of midwives who ascertain women's history on booking into the maternity services, has improved referrals as per our 4 month follow-up audit.

P250 AN AUDIT OF THE CARE AND MONITORING OF PATIENTS CO-INFECTED WITH HIV AND HEPATITIS C IN GUM IN EDINBURGH: NEED FOR BETTER DOCUMENTATION IDENTIFIED

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10.1136/sextrans-2017-053232.292

Introduction Hepatitis C (HCV) in HIV patients increases risk of cirrhosis and hepatocellular carcinoma (HCC).

Methods We used the BHIVA guidelines on co-infection to formulate our data fields to audit our compliance with these guidelines. We gathered information from 4 different IT systems used locally and paper notes; looking back over 5 years. Data fields include: Dates of HIV and HCV diagnoses, GP contact, transmission risk, latest CD4 count, ARV regimen, date ARV started, CD4 at ARV start, was HCV diagnosed when ARV started?, HCV treatment regimen, if acute HCV was treatment started within 6-12 months, referral to specialist, transplant, drug, alcohol and mental health services, HEV screening, HAV and HBV serology and vaccine, fibroscan, LFTs, liver biopsy, risk reduction discussion, cirrhosis on liver ultrasound, AFP, endoscopy, if no HCV treatment do they have annual fibrosis assessment?

Results

Abstract P250 Table 1 Number of patients identified under GUM with HCV-HIV co-infection = 16

Patients referred to speciality	12/16
Patients treated	6/16
Mode of transmission documented	2/16
Discussion of risk of transmission documented	1/16
Cirrhosis	3/16
Ever had fibroscan	5/16
Patients referred to speciality	12/16
Patients treated	6/16
Mode of transmission documented	2/16
Discussion of risk of transmission documented	1/16
Cirrhosis	3/16
Ever had fibroscan	5/16
AFP in last year	2/3
Endoscopy documented	2/3
HCV treated	2/3
Non-treated patients (10)	
Annual fibrosis assessment	0/10
Cirrhotic patients (3/16)	

Discussion In our HIV patients documentation of HCV care is spread over four IT systems and paper notes. The collation of data to ensure each patient is receiving appropriate care and monitoring is time-consuming and unwieldy, probably the main cause for incomplete monitoring. This audit identifies a need for a cohesive way of documentation for these patients.

The number next to the author indicates the page number, not the abstract number.

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