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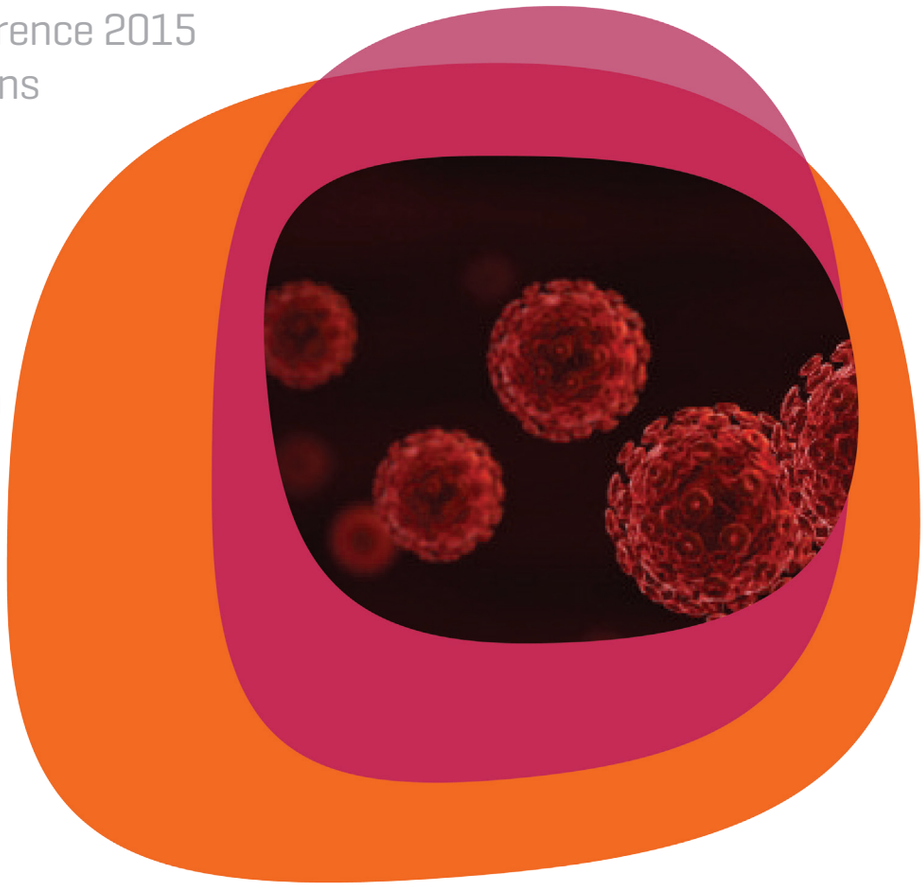
June 2015 Volume 91 Supplement 1

SEXUALLY TRANSMITTED INFECTIONS

BASHH Spring Conference 2015
Abstract Presentations
1-3 June 2015
Royal Concert Halls,
Glasgow, Scotland

Guest Editor
Dr Daniel Richardson



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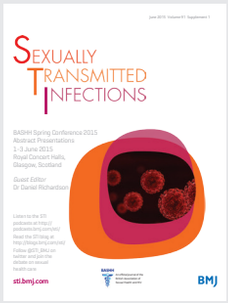

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In the following we are publishing abstracts as submitted by the authors for the BASHH Spring Conference 2015.

Poster Presentations

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[†]Professor Martin Fisher, a very active and valuable member of the BASHH conference scientific committees for many years, sadly and unexpectedly died on the 21st April 2015. He has contributed hugely to BASHH conferences and previously MSSVD & AGUM. His research and service delivery contributions to HIV and sexual health in the UK and globally have been enormous. He has been a member of several BASHH special interest groups including the MSM and HIV SIGs. He led the authorship of the BASHH PEPSE guidelines. Over and above his incredible academic achievements, he remained a hugely humble, generous, funny and friendly face of our speciality and always put our patients first.

Oral Presentations: 1st–3rd June 2015

01 IS PRE-EXPOSURE PROPHYLAXIS FOR HIV PREVENTION COST-EFFECTIVE IN MEN WHO HAVE SEX WITH MEN WHO ENGAGE IN CONDOMLESS SEX IN THE UK?

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10.1136/sextrans-2015-052126.1

Background Pre-exposure prophylaxis (PrEP) is highly protective against sexual acquisition of HIV among men having sex with men (MSM). The cost-effectiveness of PrEP will play a major role in deciding whether the NHS should introduce PrEP.
Aim To evaluate the cost-effectiveness of introducing PrEP among MSM in the UK.
Methods An individual-based dynamic stochastic model calibrated to the HIV epidemic among MSM in the UK was used. It was assumed that, from 2016, 50% of people who tested negative for HIV and who had periods of condomless sex with a long-term or casual partners would use PrEP during such periods. While on PrEP men would be tested three-monthly and PrEP discontinued if diagnosed HIV-positive or if not engaging in condomless sex for that three-month period (and restarting PrEP if again engaging in condomless sex).
Results Preliminary results indicate that the introduction of PrEP would lead to a gain in quality-adjusted life years. If current costs of antiretrovirals and PrEP are assumed for the next 30 years (as is generally regarded as good practice in the base cases analysis) PrEP introduction is not cost-effective. However, when considering likely reductions in costs of antiretrovirals and PrEP, due to the use of generic drugs, PrEP would likely be cost-effective.
Conclusion Our preliminary evaluation suggests that the use of PrEP for MSM during periods of condomless sex is not cost effective at current antiretroviral prices, but it would become cost-effective if drug prices are reduced after patent expiry date.

02 AN EPIDEMIOLOGICAL ANALYSIS OF MEN WHO HAVE SEX WITH MEN (MSM) WHO ARE PRESCRIBED HIV POST-EXPOSURE PROPHYLAXIS: IMPLICATIONS FOR WIDER PRE-EXPOSURE PROPHYLAXIS POLICY

[1]Holly Mitchell*, [1]Martina Furegato, [1]Gwenda Hughes, [1,2]Nigel Field, [1]Hamish Mohammed, [1]Anthony Nardone. *[1]Public Health England, London, UK; [2]University College London, London, UK*

10.1136/sextrans-2015-052126.2

Background/introduction Post-exposure prophylaxis following sexual exposure (PEPSE) is a potential method of preventing HIV infection in certain circumstances. Initiation of PEPSE is recommended following receptive anal intercourse with a partner of known positive or unknown HIV status from a high risk group.
Aim(s)/objectives To investigate the characteristics and risk profile of patients receiving PEPSE to determine whether this could inform development of pre-exposure prophylaxis (PrEP) policy for men who have sex with men (MSM).
Methods Data from the Genitourinary Medicine Clinic Activity Dataset (GUMCADv2) were used to investigate the characteristics of patients receiving PEPSE. Associations with PEPSE use were assessed using multivariate logistic regression.
Results Between 2011 and 2013, 14,118 patients received PEPSE, of which 63% (8,896) were MSM. Among MSM receiving PEPSE, 14% (1,213) received more than one course (maximum 13 courses), 45% (3,990) were aged 25–34 years and 75% (6,702) were of white ethnicity. 2.0% were diagnosed with HIV between 4 and 16 months after receiving their last course of PEPSE. Compared to MSM controls not receiving PEPSE, MSM receiving PEPSE were significantly more likely to be of non-white ethnicity (adjusted OR = 1.28, 95% CI 1.21–1.36), and to be diagnosed with HIV following a subsequent exposure (adjusted OR = 1.21, 95% CI 1.03–1.41).
Discussion/conclusion MSM prescribed PEPSE are at high risk of acquiring HIV infection following a subsequent exposure and may require intensive interventions to ensure course completion and reduce HIV risk behaviour. PrEP may be beneficial for high-risk MSM receiving PEPSE and also avoid the need for repeat PEPSE prescriptions.

03 IS POINT OF CARE TESTING 'UNSAFE IN THE CITY'?

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10.1136/sextrans-2015-052126.3

Background Point of care testing (POCT) for HIV is acknowledged in UK Guidelines as useful outside clinic settings, but is it safe? Our 10 year POCT programme has experienced false positives and negatives which resulted in our use of back up serology samples as standard; this differs from practice within POCT elsewhere. We had a televised false positive POCT result on "Unsafe Sex in the City" and 4 false positives in a year which caused a temporary shutdown of our POCT programme and an MRHA investigation.
Aim To review the need for back-up serology with POCT.
Method A retrospective review of all Alere Determine™ HIV-1/2 Ag/Ab Combo tests at a City Centre outreach service in 2013. Results were compared with concomitant serology.
Results POCT was provided for 382 patients. Three patients declined POCT; 2 POCT results were not documented; 10 did not have serology in parallel.

Of the remaining 367 patients: 3 true positives (0.8%); 2 false positives (0.6%); and 3 false negatives (0.8%). Negative predictive value 99.2%; Positive predictive value 60%; Sensitivity 50%; Specificity 99.4%.
Discussion This is data providing statistics for POCT in real time. Compared to advertised values Alere is underperforming. The negative predictive value is reassuring; however, the sensitivity of the test is unacceptable. Had 3 of our patients not had back up serology, they would have been unaware of their diagnosis, receiving false reassurance and potentially causing unintentional HIV transmission. Do we take this risk on board and perform POCT without back up serology?

04 HIV INCIDENCE AMONG PEOPLE WHO ATTEND SEXUAL HEALTH CLINICS IN ENGLAND IN 2012: ESTIMATES USING A BIOMARKER FOR RECENT INFECTION

[1,2]Adamma Aghaizu, [1]Gary Murphy, [1]Jennifer Tosswill, [1]Daniela DeAngelis, [1]Andre Charlett, [1]Noel Gill, [1]Samuel Moses, [2]Helen Ward, [1]Gwenda Hughes*, [1]Valerie Delpech. *[1]Public Health England, London, UK; [2]Imperial College, London, UK*

10.1136/sextrans-2015-052126.4

Introduction In England, 80% of HIV diagnoses are in sexually transmitted infection (STI) clinics. Since 2009, Public Health England offered testing for recent HIV infection.
Aim To estimate HIV incidence among STI clinic attendees in 2012.
Methods The AxSYM avidity assay, modified to determine antibody avidity, was conducted on aliquots of newly diagnosed persons and results linked to the national HIV database. An incident case was defined as avidity <0.8, no antiretroviral treatment or AIDS and viral load 400 copies/mL at diagnosis. The number of persons tested for HIV was assessed using the Genitourinary Medicine Clinic Activity Dataset. We estimated and adjusted for a 1.9% (95% C.I. 1.0%–3.4%) false recent rate and used 202 days as the mean duration of recent infection to calculate incidence rates.
Results Of 212 STI clinics in England, 150(71%) submitted specimens for recent infection testing, comprising 3,930 persons newly diagnosed; 50% were MSM. The number of HIV tests/diagnosis was 210 for all clinic attendees, 38 for MSM, 403 for all heterosexuals and 46 for black African heterosexuals. HIV incidence was 0.15% (95% C.I. 0.13–0.18%) for all attendees, 1.22% (95% C.I. 1.07–1.42%) for MSM, 1.41% (95% C.I. 1.21%-1.66%) for MSM in London, 0.03% (95% C.I. 0.02–0.04%) for heterosexuals and 0.13% (0.05–0.22%) for black African heterosexuals.
Discussion/conclusion Testing for recent HIV infection combined with routinely collected clinical data provides robust and timely national estimates of HIV incidence. HIV incidence among MSM and black African heterosexuals attending STI clinics was 40 and nine times higher respectively than among all heterosexuals, and exceeds the WHO-defined elimination threshold of 0.1%.

05 UNDERSTANDING CONTINUING HIGH HIV INCIDENCE: SEXUAL BEHAVIOURAL TRENDS AMONG MSM IN LONDON, 2000–2013

[1]Adamma Aghaizu*, [1]Anthony Nardone, [2]Andrew Copas, [2]Danielle Mercey, [2]Sonali Wayal, [2]Vicky Parsons, [2]Graham Hart, [2]Richard Gilson, [2]Anne Johnson. *[1]Public Health England, London, UK; [2]University College London, London, UK*

10.1136/sextrans-2015-052126.5

Introduction HIV incidence among men who have sex with men (MSM) has remained unchanged over the last decade despite increases in HIV testing and antiretroviral (ARV) coverage, suggesting sexual risk behaviours have increased.
Aim To examine trends in sexual behaviours among MSM and potential transmitters and acquirers of HIV.
Methods Ten serial cross-sectional surveys using self-completed questionnaires and HIV antibody testing among MSM in London gay social venues between 2000 and 2013.
Results Of 11,876 MSM, 12.8% (n = 1494) were HIV+ of whom 34% (n = 513) were undiagnosed. The proportion reporting unprotected anal intercourse (UAI) the previous year increased from 43.2% (513/1187) in 2000 to 52.6% (394/749) in 2013 ($p < 0.001$); serosorting increased from 21.4% (242/1132) to 32.6% (208/639) ($p < 0.001$). One in 20 (4.6%, n = 527) were at risk of transmitting HIV (defined as undiagnosed MSM reporting UAI or diagnosed MSM reporting UAI and not exclusively serosorting). Over the period, their median number of UAI partners increased from 2 (IQR1, 10) to 10 (IQR2,20) compared to from 0 (IQR0,1) to 1 (IQR 0,1) among other MSM. One in four (25.4%, 2633/10364) were at risk of acquiring HIV (defined as HIV – MSM reporting 1casual UAI partner in the previous year or not exclusively serosorting with any partner type).
Discussion/conclusion Between 2000 and 2013, the proportion of MSM reporting recent UAI increased, as has serosorting. We found a core group of MSM at risk of transmitting or acquiring HIV, the former with increasing UAI partner numbers. This may explain the sustained HIV incidence over the decade.

06 MEASURING THE IMPACT OF SOCIO-ECONOMIC DEPRIVATION ON RATES OF SEXUALLY TRANSMITTED INFECTION (STI) DIAGNOSES AMONG BLACK CARIBBEANS IN ENGLAND

[1]Martina Furegato*, [1]Hamish Mohammed, [2]Sonali Wayal, [2]Catherine Mercer, [1]Gwenda Hughes. *[1]Public Health England, London, UK; [2]University College London, London, UK*

10.1136/sextrans-2015-052126.6

Background/introduction Surveillance data show high rates of bacterial STIs among people of black and mixed ethnicity and those living in deprived areas.
Aim(s)/objectives To determine whether variations in bacterial STI diagnosis rates across ethnic groups are accounted for by socio-economic deprivation (SED).
Methods Data on STI diagnoses made in genitourinary medicine (GUM) clinics in England in 2013 were obtained through the GUM Clinic Activity Dataset-v2. SED was derived using the Index of Multiple Deprivation (IMD), a measure of area-level deprivation for each Lower Super Output Area of residence. Incidence rate ratios (IRRs) for each STI were derived using Poisson regression, adjusting for IMD.
Results Black Caribbeans and those of 'black other' ethnicity had the highest crude rates (per 100,000 population) of chlamydia (812.5 and 629.8), gonorrhoea (291.0 and 208.0) and syphilis (43.8 and 35.0), respectively, while rates in those of 'white British' ethnicity were 151.1, 36.3, and 5.0, respectively. Relative to 'white British', unadjusted IRRs [95% CI] for black Caribbean and 'black other' ethnicity were 10.67 [9.34–12.19] and 9.91 [8.01–12.25] for syphilis, 8.18 [7.77–8.61] and 5.76 [5.28–6.29] for gonorrhoea and 6.18 [5.99–6.37] and 5.61 [5.34–5.90] for chlamydia. After adjustment for IMD, IRRs decreased to 7.62 [6.65–8.72] and 7.26 [6.17–8.55] for syphilis, 5.77 [5.48–6.08] and 3.92 [3.60–4.28] for gonorrhoea and 4.97 [4.82–5.12] and 4.38 [4.17–4.61] for chlamydia.
Discussion/conclusion SED only partially explains the disparity in STI diagnoses rates observed across ethnic groups. The role of sexual behaviour, attitudes to risk and contextual factors should be explored to inform development of appropriate interventions.

07 DEPRESSION AND SEXUAL BEHAVIOUR AMONG MEN WHO HAVE SEX WITH MEN IN THE UK

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10.1136/sextrans-2015-052126.7

Background/introduction In the UK, HIV transmission remains ongoing among men who have sex with men (MSM). Data on mental health and sexual behaviour is limited among MSM whose HIV-status is negative/unknown.
Aim(s)/objectives To describe the association of depressive symptoms with measures of condomless sex (CLS).
Methods AURAH (Attitudes to, and Understanding of, Risk of Acquisition of HIV) is a cross-sectional questionnaire study in 20 UK STI clinics. We included MSM recruited from May 2013–January 2014 who reported anal sex in the past three months. Depressive symptoms were defined as a PHQ-9 score 10. We examined the association of depressive symptoms with: CLS in the past three months with (i) 2 partners (ii) discordant status partner(s) (unknown/HIV-positive) and self-reported STI diagnosis in the past year, using logistic regression.
Results Of 457 MSM included (20% non-white, mean[IQR] age 33[13]), 130 (29%), 167 (37%) and 184 (40%) reported 2 CLS partners, discordant CLS and diagnosed STI respectively. Fifty-nine men (13%) had depressive symptoms; 78% of whom were not receiving treatment for depression. Adjusting for age, non-white ethnicity, university education, having a stable partner and recruitment region, depressive symptoms were associated with 2 CLS partners [adjusted OR (95% CI): 1.83 (1.01, 3.31), p = 0.048], discordant CLS [2.67 (1.49, 4.77), p = 0.001] and diagnosed STI [2.03 (1.13, 3.63), p = 0.017].
Discussion/conclusion Depressive symptoms are associated with CLS and recent STI among MSM. Management of mental health may play a role in HIV/STI prevention, although causality cannot be inferred and other factors may influence both sexual behaviour and depression.

08 THE SEXUAL HEALTH AND WELL-BEING OF MEN WHO HAVE SEX WITH MEN (MSM): EVIDENCE FROM BRITAIN'S NATIONAL SURVEYS OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL)

[1]Catherine Mercer*, [1]Philip Prah, [1]Clare Tanton, [1]Nigel Field, [1]Pam Sonnenberg, [1]Kyle Jones, [2]Anthony Nardone, [1]Anne Johnson. *[1]University College London, London, UK; [2]Public Health England, London, UK*

10.1136/sextrans-2015-052126.8

Background MSM continue to be disproportionately burdened by STIs and HIV, but sexual well-being is increasingly recognised as being broader than the absence of disease.
Aim To compare the sociodemographic, behavioural, and health profiles of MSM (reporting > = 1 male partner(s), past 5 years) in Britain with men reporting sex exclusively with women (MSEW) during this time, and with MSM a decade earlier, to consider changes over time.
Methods Britain's third National Survey of Sexual Attitudes and Lifestyles (Natsal-3), a probability survey, interviewed 15,162 people aged 16–74 years (6,293 men) during 2010–2012 using computer-assisted personal-interviewing with computer-assisted self-interviewing for the more sensitive questions. Natsal-2, completed a decade earlier used a similar methodology.
Results Among all men in Natsal-3, 2.6% (n = 190) were MSM, of whom 52.5% identified as gay. Relative to MSEW, MSM were more likely to report recreational drug use (38.4% *vs.* 15.7%), treatment for depression (14.2% *vs.* 5.8%), health condition (s) they perceived affected their sexual activity/enjoyment (26.1% *vs.* 15.3%), dissatisfaction with their sex life (26.3% *vs.* 16.2%), and STI diagnosis/es (past 5 years; 16.0% *vs.* 3.7%). MSM reported larger numbers of partners than MSEW in all timeframes considered, differences that remained in multivariable analyses. No changes in MSM prevalence, profile, or behaviour were observed between Natsal-2 and Natsal-3.
Conclusion Poor sexual and mental health is more common among MSM than MSEW. There is thus an urgent need for health promotion among MSM that includes, but goes beyond, focusing on STI/HIV risk reduction and which is appropriate regardless of sexual identity.

09 BEYOND MEDICAL MANAGEMENT: THE VALUE OF PUBLIC HEALTH CONTROL MEASURES IN RESPONSE TO A HIGH RISK MSM SEXUALLY TRANSMITTED INFECTION CLUSTER

[1]Heather Anderson*, [2]Chris Lovitt, [3]Yaccub Enum, [1]Andy Williams. *[1]Barts Health NHS Trust, London, UK; [2]London Borough of Tower Hamlets, London, UK; [3]London Borough of Waltham Forest, London, UK*

10.1136/sextrans-2015-052126.9

Background/introduction In April 2014, detailed partner notification of a male patient with acute HIV, Chlamydia and gonorrhoea identified 27 different men linked to a single residential address, having listed it as their own contact address or by being the sexual partner of someone who had. Of the 27, several had attended GU services in the preceding three months with features common to their presentations including: high STI rates, selling of sex, adult film work, sex parties, chemsex, use of PEP and HIV seroconversion in the previous 12 months.
Methods The outbreak control team included a health adviser, GUM consultant, PHE health protection specialist and local authority public health. An implementation strategy was developed with immediate control measures and longer term service planning and development. A literature search established an STI outbreak linked to a single household to be a new precedent.
Results Immediate control measures:

- Outreach visit to and confidential inquiries of the residence
- Targeted messages on MSM apps
- Assuring consistent use of Treatment as Prevention
- MDT education on current MSM trends with enhanced training for health advisers
- Addition of a drugs worker clinic

Service development:

- GU clinic needle exchange
- Improved electronic patient record data output
- Comprehensive analysis of local MSM population
- Improved engagement with commissioning and drug/alcohol services

Discussion/conclusion As the trend of chemsex and sex parties continues, it is likely there will be an increase in STIs linked to households. Better geospatial analysis of STI trends and collaborative working with public health is essential for rapid identification and control of outbreaks.

O10 MSM REPORT HIGH USE OF CLUB DRUGS WHICH IS ASSOCIATED WITH HIGH RISK SEXUAL BEHAVIOUR

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10.1136/sextrans-2015-052126.10

Background/introduction The prevalence of club drug use in men who have sex with men (MSM) locally is unknown but likely associated with poor sexual health. Locally there is a large MSM population with high rates of HIV and STIs.
Aim(s)/objectives The aims of this study were to quantify club drug use in MSM locally, examine differences by HIV status and identify any association between club drug use and sexual behaviour.
Methods Patient survey of MSM attending three MSM-services (STI clinic, NGO, primary care centre) in the City. We asked MSM to report ever and recent (past month) drug use. Data were analysed using SPSS.
Results 246 MSM completed surveys from January–March 2014. The median age was 35 years (18–79). 12.7% were HIV-positive, 61.1% HIV-negative, 20.0% unsure and 5.7% never tested. The overall ever: recent club drug use was: 52.4%:21.5% cocaine, 49.4%:17.1% MDMA, 37.7%:19.3% mephedrone, 35.5%:10.5% ketamine, 24.2%:11.0% GHB/GBL, and 10.4%:2.8% crystal meth. HIV-positive MSM reported significantly higher crystal meth (Ever:37.0% v 6.9%: $p < 0.05$; Recent 13.6%:1.3%: $p < 0.05$) and GHB/GBL (Ever:48.1% v 21.2%: $p < 0.05$; Recent: 27.3%:8.9%: $p < 0.05$) use than HIV-negative/unknown. HIV-positive were significantly more likely to have injected (Slamming) club drugs ever than HIV-negative/unknown (Ever: 22.2% v 2.5%: $p < 0.05$). HIV-positive MSM using club drugs reported significantly higher rates of unprotected anal intercourse (in past 6-months) than HIV-negative/unknown (87.1% v 57.1%: $p < 0.05$).
Discussion/conclusion Club drugs use among MSM overall is worryingly high locally. In particular, HIV-positive MSM use more crystal meth and GHB/GBL, and these men are more likely to engage in unprotected anal intercourse. These data are sobering and serve as a reminder that STI and drug services should work together.

O11 CHEMSEX AND THE CITY: SEXUALISED SUBSTANCE USE IN GAY BISEXUAL AND OTHER MEN WHO HAVE SEX WITH MEN

[1]Ming Lee*, [1]Aseel Hegazi, [1]Alison Barbour, [2]Bavithra Nathan, [2]Simon Green, [2]Richard Simms, [1]Mark Pakianathan. *[1]The Courtyard Clinic, Wandswort Integrated Sexual Health, St George's Healthcare NHS Trust, London, UK; [2]Department of Sexual Health, The Wolverton Centre, Kingston Hospital NHS Foundation Trust, London, UK*

10.1136/sextrans-2015-052126.11

Background/introduction Sexualised substance use (chemsex) is an emergent phenomenon amongst some gay, bisexual and other men who have sex with men (GBMSM).
Aim(s)/objectives To describe patterns of chemsex and clinical characteristics of GBMSM attending two London sexual health clinics.
Methods Retrospective case-notes review. Data on demographics, chemsex practices, sexual behaviour, STI diagnoses and HIV status extracted from a new holistic standardised profoma used in GBMSM clinics June to December 2014.
Results 27% (n = 127) of 531 cases disclosed drug use. 59% (n = 73/124) reported chemsex, 13% (n = 15/116) injected. Drugs: Mephedrone (n = 48), GHB/GBL (n = 38), Crystal Meth (n = 28) and Cocaine (n = 8). 1/3 disclosed > one chemsex session/month. Chemsex was significantly associated with the risk taking behaviours transactional sex, group sex, fisting, sharing sex toys, HIV and hepatitis sero-discordancy ($p < 0.05$), more reported sexual partners (median 3 vs. 2 in past 3 months; $P < 0.0001$) and HIV positivity (35% vs 7% $p < 0.0001$). STIs were diagnosed more frequently in chemsex participants; Gonorrhoea (39% vs. 6% $p < 0.0001$), Chlamydia (11% vs. 4% $p = 0.05$), Hepatitis C (5% vs 0.3% $p = 0.03$) and PEPSE was more frequently prescribed (14% vs. 2% $p = 0.001$). 42% of patients perceived chemsex to have had an adverse consequences on their physical/ mental health or career.
Discussion/conclusion The majority of GBMSM reporting chemsex were HIV negative and many perceived negative consequences from chemsex. It was also significantly associated with risk taking behaviours, STIs, hepatitis C and being HIV positive. A holistic assessment of GBMSM enables the identification of opportunities for targeted prevention, health promotion and wellbeing interventions.

O12 ASSOCIATIONS BETWEEN REPEAT ATTENDANCES, SEXUALLY TRANSMITTED INFECTIONS AND CHILD SEXUAL EXPLOITATION IN UNDER 16 YEAR OLDS ATTENDING GENITOURINARY MEDICINE CLINICS

[1]Christopher Ward*, [2]Gwenda Hughes, [2]Holly Mitchell, [3]Karen Rogstad. *[1]Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK; [2]Public Health England, London, UK; [3]Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK*

10.1136/sextrans-2015-052126.12

Background Child sexual exploitation (CSE) diagnoses are difficult to make, often with no symptoms or signs. Previous reports suggested that sexually transmitted infections (STIs) are a CSE marker but currently there is no evidence for this.
Aim To investigate associations between attendance patterns and STIs with CSE to refine clinic-based CSE risk algorithms.
Methods STI diagnoses among <16 year-olds during 2012 were extracted from clinics using the genitourinary medicine clinic activity dataset (GUMCAD). Clinics with >18 STI diagnoses (all STIs) were contacted for recruitment. Cases were defined as patients with a confirmed, bacterial or protozoal STI. Controls were defined as age and gender matched asymptomatic patients at the same clinic without STIs. An online data collection tool was developed to capture additional CSE risk factors on cases and controls. A protocol was created to aid CSE definition and stratification.
Results During 2012 in England, there were 12,819 attendances of young people aged 13–15 and 2337 STIs diagnosed: 1040 (44.5%) were chlamydia, 220 (9.4%) gonorrhoea and 67 (2.9%) trichomonas. Of these infections 998 (75.2%) were aged 15, 57 (4.3%) were 13 and 1188 (89.5%) were female. 44 clinics had >18 STIs in <16s, and 21 were recruited to the study.

Discussion Considerable numbers of <16 year-olds are diagnosed with STIs in GUM clinics in England. Reporting of all these to child protection services would create considerable burdens. Additional risk information from the online tool may provide important evidence of associations between STIs and CSE in order to better use limited resources.

O13 IRIS ADVISE: ASSESSING FOR DOMESTIC VIOLENCE IN SEXUAL HEALTH ENVIRONMENTS (A PILOT STUDY)

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10.1136/sextrans-2015-052126.13

Background/introduction Sexual health and gynaecological problems are the most consistent and largest physical health differences between abused and non-abused populations. Sexual health services are well placed to identify and support people experiencing domestic violence and abuse (DVA). Most sexual health professionals have no DVA training despite NICE recommendations. IRIS (Identification and Referral to Improve Safety) is a national GP training intervention that improved the primary-care response to DVA.
Aim(s)/objectives To pilot an IRIS-based training intervention on assessing for domestic violence in sexual health environments (ADViSE), and evaluate its feasibility and effectiveness.
Methods ADViSE was developed and implemented in two sexual health clinics (Site 1 and 2) using a mixed methods design: quantitative analysis of electronic patient records and qualitative analysis of staff interviews, written feedback and anonymised cases. The intervention comprised electronic prompts, multidisciplinary training sessions, clinic materials, and specialised referral pathways to advocate-educators (AE). The pilot lasted 7 weeks at Site 1 and is ongoing at Site 2 to last 12 weeks.
Results Site 1 achieved a 10% enquiry rate (N = 267), 6% disclosure rate (n = 16) and 8 AE referrals. At 8 weeks, Site 2 has achieved a 60% enquiry rate (N = 2113), a 4.5% disclosure rate (n = 90) and 9 AE referrals. Staff reported increased confidence in identifying and managing DVA. No DVA cases were recorded in the 3 months preceding the pilots.
Conclusion/recommendations IRIS ADVISE can be successfully developed and implemented in sexual health clinics, fulfilling an unmet need for DVA training. Further evaluation through a larger multicentre study is now necessary.

O14 ATTITUDES TOWARDS HPV VACCINATION FOR BOYS AMONG SEXUAL HEALTH CLINICIANS

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10.1136/sextrans-2015-052126.14

Background In 2014 the JCVI issued an interim position statement recommending HPV vaccination for MSM under 40 through GUM clinics. BASHH advocates universal HPV vaccination.
Aim We sought sexual health clinicians' opinions on HPV vaccination of males.
Methods Online anonymous survey, circulated via BASHH.
Results 131 responses – 90 (68.7%) female. 95 (75%) doctors; 19 (14%) nurses; 8 (6%) health advisors; 9 (7%) Other. 117/124 (95%) thought there should be universal HPV vaccination. 114/118 (97%) would vaccinate a daughter, 24/27 (88%) of those with an eligible daughter had done so. 107/119 (90%) would vaccinate a son, 10/24 (42%) with a teenage son have done so. 118 (90%) support a catch up programme. 96 (73%) thought this should include all boys up to age 18. 117 (89%) thought that MSM and others should also be vaccinated.

Abstract O14 Table 1 Who should receive HPV vaccine?

MSM: Age groups (yrs)	Number (%)	Other groups	Number (%)
12–26	41/119 (34%)	HIV positive 12–26 yrs	36/123 (30%)
12–40	16/119 (13%)	HIV positive All	95/123 (78%)
18–26	3/119 (3%)	Immunocompromised other	87/123 (71%)
18–40	10/119 (10%)	Current or past HPV disease	32/123 (26%)
All	49/119 (49%)	Screen for HPV types first	1/123 (1%)

65/120 (54%) of respondents' clinics are offering (40/120) or plan to offer (25/120) HPV vaccine to MSM (Table 1).
Discussion Sexual health clinicians overwhelmingly recommend HPV vaccination of all schoolchildren. They support a targeted HPV vaccination programme in MSM within GUM services but are concerned that this strategy alone is too late and too limited.

O15 IGRA TESTING FOR LATENT TUBERCULOSIS IN COMMERCIAL SEX WORKERS

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10.1136/sextrans-2015-052126.15

Background/introduction Tuberculosis (TB) is a significant public health issue in Birmingham. Targeting 'hard to reach' groups, such as commercial sex workers (CSW), is a priority for Public Health England. Additionally, a large proportion of CSW in Birmingham are from Romania, where TB prevalence is high. We undertook a project to look for latent TB amongst CSW attending an outreach sexual health clinic.
Aim(s)/objectives To determine the:

- feasibility of testing and following up this group.
- prevalence of latent TB in this group.

Methods We offered Interferon Gamma Release Assay (IGRA) testing to all CSW attending clinic between 29.04.2014 and 24.11.2014.
Results Seventy-one women were screened. Twenty-six were IGRA positive. Of these, eighteen were followed up in TB clinic:

- Three had results suggesting previous TB and were discharged from clinic without treatment.
- Eleven were diagnosed with latent TB and treated accordingly.
- Four were diagnosed with active TB and are on appropriate therapy.
- Eight were lost to follow up.

Discussion/conclusion We demonstrated that testing is acceptable and feasible to this group. Follow-up was challenging but a review of the referral process led to improved attendance rates. To improve adherence, we used weekly rifapentine and isoniazid

for latent TB in selected cases. We are the only unit in UK to have used this regimen.

The prevalence rate of latent TB was higher than anticipated at 15%. Identifying active TB cases further demonstrated that this is a group worth targeting. These preliminary results led to an extension of this project.

O16 ACCESS TO GUM CLINICS IN THE UK – A WORSENING PICTURE?

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10.1136/sextrans-2015-052126.16

Background/introduction In 2004 the Department of Health introduced a mandatory target for 100% of all patients in England to be offered 48-hour appointments by 2008. In 2010 these targets were removed and in April 2013 further changes to healthcare provision were introduced, with local authorities commissioning GUM (genitourinary medicine) services.
Aim(s)/objectives To assess the effect of recent commissioning changes to the accessibility to GUM clinics.
Methods During November 2014 male and female researchers telephoned all UK GUM clinics that were open for more than one day per week. Researchers contacted clinics twice: firstly presenting with symptoms consistent with an acute sexually transmitted infection and secondly requesting an appointment for an asymptomatic screen.
Results Of 236 clinics contacted, 89% could accommodate symptomatic 'patients' within 48 h with 53% of these on a walk-in basis only. Suggested waiting times ranged between 20 min and 3 h. 20% of asymptomatic 'patients' were unable to book an appointment and 58% of appointments were offered within 48 h. 86% of asymptomatic 'patients' were offered either a walk in service or appointment within 48 h.
Discussion/conclusion Overall 88% of 'patients' could be offered a time to be seen in a GUM clinic within 48 h, lower than last year's figure of 95% and the BASHH standard of 98%, suggesting service access has deteriorated. Further work will include a postal questionnaire to lead clinicians to evaluate their expectations on service access and visits to 33% of GUM clinics to explore the relationship between suggested waiting times and reality.

O17 WHEN'S BEST TO TEXT? OPTIMUM TIMING OF SMS APPOINTMENT REMINDERS

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10.1136/sextrans-2015-052126.17

Background/introduction Throughout healthcare settings 'did not attend' (DNA) rates impact heavily on service efficacy and are estimated to cost the NHS £600 m per year. Short message service (SMS) texts have been shown to reduce the DNA rates amongst Sexual Health patients.
Aim(s)/objectives The aim of this project was to assess the optimum timing of SMS appointment reminders and its impact on the non-attendance rates in our HIV and Sexual Health service.
Methods For three consecutive four week periods between 30/12/2013 and 06/04/2014, in addition to the routine 'on the day' SMS reminder an extra reminder was sent 1, 2 or 3 days prior to patient appointments. Data was collected concerning patient attendances during these periods for pre-booked appointments for HIV and Sexual Health patients. Statistical significance was calculated using Fisher's Exact test and Pearson's correlation coefficient as appropriate.
Results Attendance was monitored for 1,271, 1,215 and 1,264 patients in each 4 week group respectively. Amongst HIV patients, DNA rates fell as the time increased between the appointment and sending the extra SMS reminder. For Sexual Health patients, DNA rates fell as the time was decreased between the appointment and the extra SMS reminder. For both patient groups the gradient of this fall was statistically significant.
Discussion/conclusion This small project has demonstrated the optimum timing of SMS reminders appears different for HIV and Sexual Health patients. HIV patients had lower DNA rates when texted further from the appointment time, whereas Sexual Health patients DNA'd less often if texted nearer to their appointment. Further work is needed confirm the generalisability of our findings and reasons underpinning them.

Abstract O17 Table 1 When is best to text

	DNA Rate SMS sent 1 day prior to appointment	DNA Rate SMS sent 2 days prior to appointment	DNA Rate SMS sent 3 days prior to appointment	*1 vs 2 days* (*p*)	*1 vs 3 days* (*p*)	*2 vs 3 days* (*p*)	*Correlation coefficient* (*p*)
HIV Patients	16.60%	16.30%	10.24%	1.0000	**0.0483**	0.0534	**0.042**
Sexual Health Patients	8.26%	9.96%	11.16%	0.1609	**0.0167**	0.3665	**0.014**

O18 USE OF A NOVEL QUEUE MANAGEMENT SOFTWARE PROGRAM TO IMPROVE PATIENT SATISFACTION AT A LARGE URBAN GUM CLINIC

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10.1136/sextrans-2015-052126.18

Background/introduction Since opening a new clinic there has been high patient flow particularly at weekends. Even with adequate staffing and patients performing self-triage, waiting times sometimes exceed three hours. This frequently resulted in patient aggression towards reception staff, poor patient feedback about waiting times and staff complaints with incident reporting forms (IR1). In October 2014 – new software was introduced to improve patient satisfaction.
Methods Upon entry to the clinic all symptomatic patients were registered on the program which automatically sent a text message informing them of their place in the queue. They were then

invited by reception staff to leave the clinic until they were sent another text when they were due to be seen. Patients in possession of a Smartphone could refresh a link to check their place in the queue at any time. IR1s and patient feedback were assessed before and after implementation

Results Average no of symptomatic patients seen over a weekend was 70 with an average wait time of 89 min. In the 4 month period prior to the software implementation there were 6 IR1 forms received from staff about patient aggression. In the 4 month period after its introduction there were none. Two months post its introduction the average number of patient complaints about waiting times received was 1 from an average of 4 prior to its use.

Conclusion The introduction of the queuing software has been an inexpensive and effective method of reducing complaints about patient waiting times and improving patient satisfaction with the service.

O19 CAN EXPRESS TREATMENT REDUCE ONWARD TRANSMISSION?

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10.1136/sextrans-2015-052126.19

Background/introduction The introduction of onsite Cepheid® GeneXpert diagnostics for asymptomatic STI screens cut 'test to treatment' time by 190 h.

Aim(s)/objectives To evaluate the Public Health benefit of faster treatment.

Methods Patients with chlamydia (CT) and/or gonorrhoea (GC) over 8 weeks in February 2014 were retrospectively identified. We compared the timing of testing, treatment and number of recent sexual partners with a control group from November 2013. Assuming rate of partners remains unchanged, we calculated 'partners spared' exposure per infected patient due to faster treatment.

Results 431 patients were identified with CT and/or GC infection. 81% (349/431) were MSM. Median age was 29 years. 23% of index patients disclosed high risk behaviour including fisting, chemsex and injecting drug use. Median 'test to treatment' time dropped from 238 h to 48 h. The number of partners spared exposure was 0.5 per index case. This equates to a total 196 partners spared exposure over the study period.

Discussion/conclusion For every two people diagnosed with an infection, one partner was spared exposure. Limiting the duration of infectivity and the potential for onward transmission has clear public health benefits and is of particular value in this cohort with multiple partners who engage in high-risk behaviour.

O20 ON-LINE STI TESTING SERVICES: IMPROVING ACCESS, EFFICIENCY AND USER EXPERIENCE

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10.1136/sextrans-2015-052126.20

Background/introduction There are many barriers to accessing sexual health and HIV testing services. Novel service models could address this. On-line testing may provide a solution.

Aim(s)/objectives To evaluate the acceptability and potential impact of on-line STI testing.

Methods We developed a dedicated, secure website for free on-line STI testing. Website content and testing process was iteratively designed in response to user feedback. Simple questions identify those most at risk or symptomatic and signpost to local services. Clients order self-taken NAAT tests for chlamydia (CT) and gonorrhoea (GC) and a pin-prick blood test for syphilis and 4th generation HIV testing and post them to the laboratory. Results are received by text. In November 2014 we piloted the process by offering it to clients attending 2 sexual health services.

Results 47 clients used the service. 31 (65.9%) men, of whom 5 (16%) were MSM. Mean age was 29 (range 19–64). Mean time to receipt of results was 3 days (range 0–8). 18 (38.3%) clients received their results on the same day the sample was taken. One client tested positive for syphilis. All other tests were negative. User feedback was predominantly positive, with specific reference to its speed and simplicity. 8/47 (17%) left negative feedback about the pinprick process, which they found difficult or unpleasant.

Discussion/conclusion The service was highly acceptable. Rapid results turnaround was more efficient than local 'traditional' services. The service (which soon becomes available to all local residents) will contribute significantly to local STI/HIV testing and prevention strategies.

O21 SECURING EXCELLENCE IN CHLAMYDIA SCREENING OUTCOMES ON A SHRINKING BUDGET

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10.1136/sextrans-2015-052126.21

Background/introduction The National Chlamydia Screening Programme (NCSP) recommends opportunistically screening sexually active 15 to 24 year olds annually and on change of partner. Through a number of changes to the delivery of screening, Leeds has maintained a higher than average detection rate indicator (DRI) despite declining spend. We describe these changes and corresponding DRIs.

Aim(s)/objectives To review and re-structure chlamydia control activity to provide greater value for money.

Methods A multi-professional steering group was established and a strategic approach taken to commission chlamydia within sexual health services. Our approach included: screening, treatment and partner notification embedded within contraception and sexual health services; commissioning of online testing and an enhanced pharmacy scheme; signposting website developed; phasing out financial incentives for General Practitioners (GP); reducing outreach testing, marketing and staff.

Results In 2014 £371k was spent on screening activities (£538k 2010/11). 2014 Q1-Q2 DRI was 3,104 (2,168 England; 2,325 Yorkshire and Humber) and 2,511 (1,888 England; 2,128 Y&H), respectively compared to 2,698 (2,093 England; 2,367 Y&H) and 2,355 (1,947 England; 2,068 Y&H) for equivalent time periods in 2013. In 2013 most tests were performed in GP (30%) followed by GUM (26.6%), Internet (26.8%) and CASH (13.5%). Positivity across all settings in 2013 was 9.5%.

Discussion/conclusion By concentrating activity in venues with higher positivity, in line with guidance from the NCSP, it has been possible to achieve the DRI target whilst working within tighter economic constraints. In particular, outreach screening was costly and produced low volumes of tests with low positivity.

O22 PERFORMANCE OF THE BD MAX™ CT/GC/TV ASSAY FOR DETECTION OF CHLAMYDIA, GONORRHOEA AND TRICHOMONAS

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10.1136/sextrans-2015-052126.22

Background Chlamydia, gonorrhoea and trichomonas infections remain highly prevalent with annual WHO estimates of 106, 107 and 276 million cases respectively. Screening for all 3 infections in a single assay could improve control efforts.
Aim This study assessed the performance of the BD MAX™ CT/GC/TV (BD MAX) for detection of chlamydia, gonorrhoea and trichomonas DNA compared to routine diagnostic methods.
Methods Urine, patient-collected vaginal and endocervical specimens were obtained from 1854 women. BD MAX assay results were compared to TV culture (InPouch), TV wet mount, Aptima AC2 and TV assays and the BD Viper™ CTQ^x/GCQ^x assays.
Results Prevalence for chlamydia, gonorrhoea and trichomonas was 7.3, 2.3 and 14.7%, respectively. Sensitivity estimates ranged from 92.2–99.2, 94.9–95.1 and 92.9–96.1 for chlamydia, gonorrhoea and trichomonas, respectively. Specificity estimates for each test were 98.6. Of the 128 out of 1758 (7.3%) women with chlamydia infections, concomitant gonococcal and trichomonal infections were present in 11.7 and 12.5%, respectively. The sensitivity of the assay for chlamydia when co-infections were present ranged from 92.6–96.1%. Similarly the sensitivity of the gonorrhoea and trichomonas detection was not affected by the presence of concomitant chlamydial infections with estimates ranging from 93.8–100% and 89.5–100%, respectively.
Discussion The performance of the BD MAX assay was similar to that of other molecular diagnostic assays. A substantial proportion of women with chlamydia are co-infected with gonorrhoea and/or trichomonas. Trichomonas was more prevalent than chlamydia and gonorrhoea combined. Detection of all three infections in a single assay may improve identification and treatment of these STI.

O23 *PORA* PSEUDOGENE DELETION AMONGST *NEISSERIA GONORRHOEAE* ISOLATES FROM THE GONOCOCCAL RESISTANCE TO ANTIMICROBIALS SURVEILLANCE PROGRAMME (GRASP)

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10.1136/sextrans-2015-052126.23

Background/introduction In the last four years, isolates of *N. gonorrhoeae* have been identified in Australia, Sweden, Scotland and England which lack the gonococcal porA pseudogene and consequently result in negative results in the diagnostic *porA* pseudogene real-time-PCR (RT-PCR) for *N. gonorrhoeae*.
Aim(s)/objectives This study sought to determine the prevalence of *porA* pseudogene negative isolates amongst isolates received at Public Health England (PHE) through the national gonococcal resistance to antimicrobials surveillance programme (GRASP).
Methods DNA lysates were prepared from 533 *N. gonorrhoeae* isolates received from 20 centres via GRASP during 2011. Any isolate with a RT-PCR *por A* pseudogene negative result was repeated from a fresh culture and the *porA* gene was additionally DNA sequenced. Isolates were additionally tested using the gonococcal *opa* gene RT-PCR.
Results Four isolates (4/533, 0.8%) were found to be reproducibly negative with the *porA* pseudogene RT-PCR, but were positive with *opa* gene RT-PCR. DNA sequencing determined that two isolates contained the *Neisseria meningitidis porA* gene. Both isolates were from patients attending a clinic in SouthLondon.
Discussion/conclusion Less than one percent of the GRASP isolates from patients attending clinics across England expressed the meningococcal *porA* gene and therefore tested negative on the in-house *porA* assay. The low prevalence indicates that these isolates do not present a major diagnostic or public health problem. However, microbiologists should remain vigilant for any isolates giving anomalous results and when using the *porA* pseudogene RT-PCR consider multiplexing it with the *opa*-gene RT-PCR.

O24 CONFIRMING GC NAAT RESULTS: IS IT ALWAYS NECESSARY?

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10.1136/sextrans-2015-052126.24

Introduction Current guidance recommends that all specimens testing positive using a *N. gonorrhoeae* Nucleic Acid Amplification Test (GC NAAT) be confirmed using a second test with an alternative target, in order to achieve a positive predictive value above 90%.
Aim To determine rates of GC NAAT confirmations by primary screening test and specimen site.
Methods 994 specimens which were GC NAAT positive at local laboratories were sent for confirmation using an in-house multiplex PCR with *Por*A and *opa* gene targets. A correlation between the confirmatory real-time PCR results, specimen site and GC screening NAAT was undertaken. For the purposes of this analysis equivocal results were regarded as positive and inhibited results were excluded.
Results Overall, 57% of specimens examined could be confirmed as GC positive using the in-house real-time PCR test (Table 1).
Discussion High rates of confirmation can be achieved when examining genital, rectal and urine specimens irrespective of the GC screening NAAT. However >90% confirmatory rates were only achieved when examining male urine specimens which had been screened using the Probetec and Cobas Amplicor tests,

although caution should be applied if extrapolating this data to low prevalence settings. Poor confirmation rates from throat specimens is probably due to cross-reactivity with commensal Neisseria, and highlights confirmation is essential when testing these samples.

Abstract O24 Table 1 Confirmatory rates by Specimen site and GC NAAT screening test

	Genital Swab (Female) [n = 119]	Urine (Male) [n = 84]	Rectal [n = 97]	Throat [n = 694]
Probetec GC Qx (Becton Dickinson)	78.7% (37/47)	94% (47/50)	85.1% (23/27)	44.2% (248/587)
Cobas Amplicor (Roche)	83.3% (50/60)	91.3% (21/23)	79.4% (27/34)	48.2% (27/56)
RealTime CT/NG (Abbott)	83.3% (10/12)	72% (8/11)*	80.5% (29/36)	88.2% (45/51)

*Small numbers – interpret with caution

O25 USE OF CEFTRIAXONE AND DOXYCYCLINE WHEN TREATING GONORRHOEA: IS IT PRESCRIBED APPROPRIATELY?

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10.1136/sextrans-2015-052126.25

Background National gonorrhoea treatment guidelines recommend ceftriaxone with azithromycin as first-line therapy, but doxycycline is recommended instead of azithromycin for patients with gonococcal pelvic inflammatory disease (PID). In 2013, 86.5% of patients in the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) were treated with the recommended therapy, but 3.9% were treated with doxycycline instead of azithromycin.

Objectives The objective of this analysis was to determine whether ceftriaxone plus doxycycline were prescribed for appropriate indications.

Methods Using GRASP 2013 data, patients prescribed the recommended therapy were compared with patients prescribed ceftriaxone and doxycycline, and associations were assessed using univariate and multivariate logistic regression.

Results In 2013, of the 913 patients prescribed ceftriaxone and azithromycin, 45.9% were men who have sex with men (MSM), 20% were women and 34.1% were heterosexual men while, of the 45 patients prescribed ceftriaxone and doxycycline, 64.4% were MSM, 28.9% were women and 6.7% were heterosexual men ($p = 0.001$). Of those prescribed ceftriaxone and doxycycline, 22.2% were MSM with chlamydia co-infection and 17.7% were women with PID. On multivariate analysis, MSM co-infected with chlamydia (aOR 3.4, 95% CI, 2.5–4.6; $p = 0.001$) and women diagnosed with gonococcal PID (OR,144.8, 95% CI, 24.2–864.0; $p < 0.001$) were more likely to be prescribed ceftriaxone and doxycycline.

Conclusion Less than a fifth of prescriptions for ceftriaxone with doxycycline were issued to treat gonococcal PID. Use of ceftriaxone with doxycycline may be preferred to treat MSM co-infected with chlamydia by some clinicians. However, as levels of tetracycline resistance in gonorrhoea are high, this may not provide the dual treatment coverage required.

O26 GONORRHOEA TEST-OF-CURE BY POST MAINTAINS RETURN RATE

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10.1136/sextrans-2015-052126.26

Background/introduction BASHH guidelines recommend test-of-cure (TOC) in all cases of *N. gonorrhoeae* (NG) 2 weeks after treatment. Previously patients re-attended our clinic in person for TOC. To create capacity in the clinic, we introduced NG TOC postal packs for MSM following treatment.

Aim(s)/objectives To evaluate TOC return rate and patient satisfaction with the service development.

Methods MSM with proven NG were given postal TOC packs at treatment. Each pack contains appropriate NAAT sampling kits for site of diagnosed infection (rectal, throat, urine) and written instructions, patient satisfaction survey and partner notification questionnaire. Patients are instructed to return TOC samples by post in a provided Royal Mail Safebox. We processed samples using our in-house GeneXpert system; results are sent by SMS.

Results During November 2014, 136 NG TOC packs were dispensed. 76 (55.9%) patients returned postal packs; 28 (20.6%) attended for TOC in person, giving overall TOC rate, 76.5%. NG TOC rate in October 2014 was 75.8%. The median time from treatment to sending TOC results was 19 d (IQR:16–24d). NG TOC positivity rate was 12.5% (13/104). 65 patient satisfaction surveys were returned. Most responders found postal TOC easy to use (81.5%; 53/65). 24.6% (16/65) responders would have preferred to attend in person for TOC.

Discussion/conclusion Postal testing is an acceptable NG TOC method which, when combined with the option to return in person, reduced unnecessary follow-up visits while maintaining TOC return rate. The high TOC positivity rate reinforces the importance of continuing to retest patients with NG after treatment.

O27 HIGH RATES OF MACROLIDE RESISTANCE IN *MYCOPLASMA GENITALIUM*

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10.1136/sextrans-2015-052126.27

Background/introduction Macrolide resistance has been previously reported in *Mycoplasma genitalium* (MG), however due to limited diagnostics, studies have been mainly restricted to specific geographical areas and small numbers of positive samples.

Aim(s)/objectives To determine the rate of macrolide resistance in MG specimens.

Methods Eighty-five MG positive specimens (72 from males, 13 from females) that had been referred for MG centralised testing (between 2010–2014), from 17 centres across England and Wales were blinded and anonymised. Specimens were then examined using a *23S rRNA* PCR followed by full DNA sequence analysis. The Chi Square test was used to compare data sets.

Results *23S rRNA* PCR was successful in 86% (73/85) of specimens. Of the specimens examined, 84% (61/73) harboured single nucleotide polymorphisms (SNP) associated with macrolide resistance (Table 1). Significant differences were observed between the rates of macrolide resistance in male [95% (58/61)] and female [25% (3/12)] patients [P = <0.001]. Twelve

specimens 17% (12/73) [male (3/61 (5%) and female 9/12 (75%)] were wild-type and therefore assumed to be sensitive to macrolides.

Discussion/conclusion Eighty-four percent of MG specimens examined had SNPs associated with macrolide resistance. These levels of resistance are higher than previously documented in other studies and highlight the need for (i) greater access to MG diagnostic testing and (ii) a requirement for more effective antimicrobials if MG infection is to remain a treatable in the future.

Abstract O27 Table 1 Characteristics of point mutations in the *23S rRNA* gene from 73 MG specimens

Sequence identified	Phenotype	No. specimens (73)	No. by sex (M – 61, F – 12)
Wild-type	Sensitive	12/73 (17%)	M – 3/61 (5%)
			F – 9/12 (75%)
A2058G	Resistant	22/73 (31%)	M – 21/61 (34%)
			F – 1/12 (8%)
A2058T	Resistant	1/73 (1%)	M – 0/61 (0%)
			F – 1/12 (8%)
A2059G	Resistant	34/73 (47%)	M – 32/61 (53%)
			F – 2/12 (17%)
A2059C	Resistant	4/73 (6%)	M – 4/61 (7%)
			F – 0/12 (0%)

O28 TREATMENT OF *MYCOPLASMA GENITALIUM* WITH AZITHROMYCIN 1 G IS LESS EFFICACIOUS AND ASSOCIATED WITH INDUCTION OF MACROLIDE RESISTANCE COMPARED TO A 5 DAY REGIMEN

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Background *Mycoplasma genitalium* (MG) is an emerging important STI. Failure rates with azithromycin 1 g appear to be increasing. This may be due to the emergence of macrolide antimicrobial resistance as a consequence of extensive use of azithromycin 1 g. An extended regimen of azithromycin 500 mgs on day one then 250 mgs daily for 4 days (5 day regimen) was introduced in the 1990s for treatment of MG and has high efficacy rates (if no pre-existing macrolide resistance) and is less associated with induction of macrolide resistance. There are no comparative trials of the two regimens.

Aim To undertake a meta-analysis of MG treatment studies using the two azithromycin regimens to determine which is more effective.

Methods MG treatment studies were included if: patients were initially assessed for macrolide resistance genetic mutations, were treated with azithromycin 1 g or 5 days, and those who failed were again resistance genotyped. Sensitivity analyses included only patients without prior treatment.

Results Five studies were identified. Compared to the 5 day regimen, azithromycin 1 g had higher failure risk (difference: 11.8%, 95% CI: 7.3%, 16.2%) and more developed macrolide resistance (risk difference: 11.8% (8.3%, 15.3%)). The 5 day regimen included 52 patients with prior doxycycline treatment. Sensitivity analysis showed a failure risk difference of 9.2% (0.9%, 17.5%). Resistance risk did not change.

Conclusion Azithromycin 1 g is more likely to result in treatment failure and the development of macrolide antimicrobial resistance than 500 mgs on day one then 250 mgs daily for 4 days.

O29 TV IN PRIMARY CARE – IS THERE MORE OUT THERE THAN WE THINK?

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10.1136/sextrans-2015-052126.29

Background Tests for *Trichomonas vaginalis* (TV) are often not performed on samples submitted from primary care because the prevalence is assumed to be too low for testing to be cost effective. Current microbiological testing involves wet mount microscopy (sensitivity 50%) or culture (sensitivity 75%). In practice, sensitivity rates may often be lower than this, due to deterioration of specimens during transport to the laboratory. The Aptima TV NAAT test has recently been approved for use (sensitivity ~100%).

Aim To determine the positivity of TV in symptomatic and asymptomatic women at risk of an STI, seen in primary care using Aptima TV NAAT.

Methods The Aptima TV NAAT test was performed on 6716 remnant samples from women undergoing chlamydia and gonorrhoea NAAT testing in primary care.

Results The positivity of TV in symptomatic and asymptomatic patients from primary care was **2.6%** (86/3271) and **1.2%** (40/3445) respectively compared with an expected positivity of 0.3% and 0.1%, based on existing methods. TV positivity rates varied between GP practices from 0% to 4.8%. Higher positivity rates were observed in practices serving areas of deprivation, as well as those with higher black and minority ethnic populations.

Conclusions This is the first study to report TV positivity, using a TV NAAT, in unselected women presenting for STI testing in

Abstract O28 Table 1 Treatment of *Mycoplasma genitalium*

		Treated with 5 day regimen			Number treated with 1 g regimen		
Study	Sample size	Total	Failure	Resistance	Total	Failure	Resistance
Anagrius *et al*. 2013	195	78	1 (1.3%)	0	117	10 (8.5%)	7 (6.0%)
Twin *et al*. 2012	66	0			66	14 (21.2%)	14 (21.2%)
Couldwell *et al*. 2013	12	0			12	4 (33.3%)	3 (25%)
Walker *et al*. 2013	28	0			28	3 (10.7%)	3 (10.7%)
Bissessor *et al*. 2014	99	0			99	11 (11.1%)	11 (11.1%)
Total	400	78	1 (1.3%)	0	322	42 (13.0%)	38 (11.8%)

primary care. In view of the wide variation in positivity by locality, it is likely testing for TV will be cost effective in some areas. Ongoing surveillance may be necessary to identify those at risk.

O30 SERVICE PROVISION AND ECONOMIC IMPLICATIONS OF IMPLEMENTING NAAT TESTS FOR *TRICHOMONAS VAGINALIS* IN WOMEN ATTENDING GENITOURINARY MEDICINE CLINICS AND PRIMARY CARE

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10.1136/sextrans-2015-052126.30

Background/introduction Laboratory tests for *Trichomonas vaginalis* using culture and microscopy in current practice have low sensitivity, however new, highly sensitive PCR-based nucleic acid amplification tests (TV NAATs) have been approved e.g. Aptima TV NAAT. It is not known how to optimally deploy these new tests in different settings.
Aim(s)/objectives To assess the cost-effectiveness of new TV NAAT tests for the diagnosis of TV infection in women attending genitourinary medicine (GUM) and primary care clinics. To inform national decision-making about who should be offered TV testing.
Methods We analysed data from TV tests in residual chlamydia/gonorrhoea samples from nearly 9,000 women. We conducted notes review in GUM clinics to understand current practice. We compared current and proposed pathways for management of TV. We calculated the cost of testing for TV in GUM and primary care.
Results Table 1 shows the breakdown of test results by symptomatic/asymptomatic and setting and indicates the current and new cost of testing. (NB. Provisional data, study closed 31/1/2015). Compared with current testing practice, TV NAAT testing detected an additional 41 cases from GUM. In primary care few samples were sent for laboratory testing; only 15 out of 126 NAAT positive cases would have been detected.
Discussion/conclusion TV NAAT tests detected many more infections than current testing. Nationally, this translates to an increase in GUM from 6,000 cases to 23,400 cases annually. Overall, the crude cost of adding TV NAAT testing to all chlamydia and gonorrhoea tests is £307 per additional infection diagnosed.

O31 MENSES – TO TEST OR NOT TO TEST?

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10.1136/sextrans-2015-052126.31

Background/introduction Varied advice is given to women about testing for chlamydia (CT) and gonorrhoea (NG) whilst menstruating. Some are advised it makes no difference, others are advised not to test or are offered urine sampling instead of a vulvovaginal swab. There is no published evidence to inform such advice.
Aim(s)/objectives To determine if menses affects the performance of CT/NG NAATs.
Methods Using data collected in a large CT/NG NAATs diagnostic study we compared the prevalence of infections in menstruating women versus those not menstruating.
Results Of the 3973 study participants 162 (4%) were menstruating and 3811 were not. 30 (18.5%) menstruating women had CT and 10 (6.2%) had NG; 380 (10%) non-menstruating women had CT and 90 (2.4%) had NG. Menstruating women were more likely to be diagnosed with CT (OR 2.05; p = 0.0008) and NG (OR 2.72; p = 0.0055); less likely to have had a previous STI (OR 0.66) and to have cervicitis (OR 0.21) but more likely to be a STI contact (OR 2.13) and have bacterial STI symptoms (OR 1.36). After adjusting for these confounding variables menstruating women remained more likely to be diagnosed with CT (Adjusted OR 1.98; 95% CI 1.27–3.09; p = 0.003).
Discussion/conclusion Menses does not have a negative effect of the performance of CT/NG NAATs; in fact the prevalence of infections was higher in menstruating women. Only 4% of women were menstruating suggesting that women avoid attending for STI testing during their period unless really necessary. Hence testing should be performed during menstruation using vulvovaginal or endocervical swabs.

O32 ASYMPTOMATIC NEUROSYPHILIS IS UNLIKELY IN HIV INFECTED PATIENTS AFTER TREATMENT FOR EARLY SYPHILIS WITH BENZATHINE PENICILLIN G

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10.1136/sextrans-2015-052126.32

Background/introduction Benzathine penicillin G (BPG) does not cross the blood-brain barrier. Some experts believe that BPG may be ineffective when treating patients co-infected with HIV and syphilis.
Aim(s)/objectives To establish the risk of asymptomatic neurosyphilis (ANS) after treatment of early syphilis in HIV positive patients with single dose BPG.
Methods HIV patients with early syphilis were offered a post-treatment lumbar puncture if their CD4 count was <350 and/or their serum RPR >16. Patients with clinical neurosyphilis were excluded. ANS was defined as a positive CSF RPR, or CSF white blood cells >20/mm^3 plus CSF TPPA >1:320.

Abstract O30 Table 1 *Trichomonas vaginalis* test results in symptomatic and asymptomatic women in GUM and primary care

		Positive (current)	Negative	Total (current)	Positivity	Current cost	New cost	Cost per extra case
Genitourinary medicine	**Symptomatic**	22 (9)	497	519 (440)	4.2%	£3,489	£3,955	£35.8
	Asymptomatic	28 (0)	1571	1599 (0)	1.8%	£0	£12,184	£435.2
Primary care	**Symptomatic**	86 (13)	3185	3271 (1651)	2.6%	£13,092	£24,925	£162.1
	Asymptomatic	40 (2)	3405	3445 (497)	1.2%	£3,941	£26,251	£587.1
Total		**176 (24)**	**8658**	**8834 (2588)**	**2.0%**	**£20,523**	**£67,315**	**£307.8**

Results 64 patients participated (median CD4 417/mm^3, range 84–1100). 50 of the patients were treated with single dose BPG. Only one patient had ANS (prevalence 1.56% 95 CI 0.04–8.4) with CSF RPR negative, CSF TPPA 1:1280 and lymphocytes 45/mm^3. Two patients had a pleocytosis (50 and 22 white cells/mm^3 respectively) with negative CSF RPR and CSF TPPA and thus did not meet diagnostic criteria for ANS per protocol.
Discussion/conclusion Our study suggests that single dose BPG is effective treatment for early syphilis in HIV co-infected patients. We will present more data to support this conclusion.

O33 AEROBIC VAGINITIS: PREVALENCE, MANAGEMENT AND OUTCOMES IN A LARGE INTEGRATED SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.33

Background/introduction Aerobic vaginitis (AV), a syndrome of abnormal vaginal microflora, was first described in 2002 and is increasingly recognised as a condition distinct from bacterial vaginosis that may require different management.
Aim(s)/objectives To describe the prevalence of moderate-to-severe AV, its management and outcomes in a UK setting.
Methods We included all women presenting to our large integrated sexual health service who met criteria for gynaecological examination and near-patient microscopy. A single biomedical scientist scored the wet mount according to the method of Donders *et al*. If the score was 5 or above (indicating moderate to severe AV) the requesting clinician was informed. We reviewed case notes to determine treatment choice and outcome.
Results From 1/12/13 to 30/11/14, 1616 wet films were read. Overall, 314 (19.4%) had an abnormal AV score (11 (0.7%) severe AV (score >6), 61 (3.8%) moderate AV (score = 5–6), 253 (15.7%) slight AV (score = 3–4)). Patients with severe AV were significantly older than those with moderate AV (mean age 42.7 vs 32.0 years, p = 0.04), but only 6 (8.3%) patients had atrophic change. Among patients with AV scores of 5 or more, trichomonas was seen in 2 (2.8%) patients, 13 (18.5%) had evidence of yeast infection. First-line treatment included intravaginal clindamycin (49.7%), oral metronidazole (27.3%), antifungals, penicillins, acidification gel and local oestrogen. Symptoms persisted in 19.4%, re-occured in 4.2% and resolved in 43%, with 33% not re-attending.
Discussion/conclusion Patients with moderate-to-severe AV scores are challenging to manage with a high proportion of repeat attendance. Severe AV occurs in an older population.

Clinical Case Studies: 2nd June 2015

C1 CASE SERIES: MANAGING DESQUAMATIVE INFLAMMATORY VAGINITIS IN TRANS-MEN

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10.1136/sextrans-2015-052126.34

Background/introduction Desquamative inflammatory vaginitis (DIV) is an uncommon condition characterised by florid vaginal inflammation causing vaginal discharge, vulval pain and dyspareunia. Microscopy typically shows absent vaginal flora, numerous polymorphs and immature parabasal cells with no mature epithelia. The pathogenesis of DIV is currently unknown but may involve tissue kallikrein-related peptidases which are regulated by sex hormones and corticosteroids.

Case-1: 35-year-old trans-man on testosterone for 18-months presenting with yellow vaginal discharge, vestibular pain and dyspareunia. Examination revealed vaginal inflammation and mucopurulent discharge. Microscopy was typical of DIV. He was treated with intravaginal clindamycin reporting a good response.

Case-2: 26-year-old trans-man on testosterone for 7-years presenting with vaginal discharge, dyspareunia and post-coital bleeding. Examination revealed inflamed friable vaginal mucosa. Microscopy findings were typical of DIV and he started treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

Case 3: 20-year-old trans-man with vaginal discharge and post-coital bleeding who started testosterone 6-months earlier. Examination and microscopy findings were typical of DIV. He commenced treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

Case 4: 19-year-old trans-man on testosterone for 9-months presenting with vaginal pain and bleeding. Examination and microscopy were typical of DIV. He started treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.
Discussion We present four cases of DIV in trans-men possibly associated with androgens responding to intravaginal clindamycin and steroids. As well as causing significant morbidity DIV may increase transmission of sexually-transmitted-infections in trans-men: we need to understand more about its aetiology, management and long term outcomes.

C2 GONOCOCCAL TENOSYNOVITIS IN TWO HIV-INFECTED HETEROSEXUAL MALES: DELAYED DIAGNOSES FOLLOWING NEGATIVE URINE NAAT TESTING

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10.1136/sextrans-2015-052126.35

Background Disproportionately high gonococcal incidence rates amongst men have altered the clinical picture of disseminated gonococcal infection (DGI). The 'classical' female patient experiencing a triad of arthritis, tenosynovitis and cutaneous lesions no longer predominates. We present two cases emphasising the need for thorough investigation with evident clinical signs of DGI.
Cases A 48 year old Nigerian heterosexual male presented with a 6 cm inguinal mass and oral hairy leukoplakia. Impression was of lymph node abscess; HIV testing was positive. Urine Nucleic Acid Amplification Testing (NAAT) for chlamydia and gonorrhoea (CT/GC) was negative. Subsequently he developed a swollen tender left wrist. Inguinal abscess aspiration for NAAT testing returned a positive gonococcal result. Treatment was instigated with intravenous ceftriaxone for 4 days, subsequently switching to cefixime for a further week. 3 weeks later his wrist swelling resolved.

A 50 year old HIV-positive British heterosexual male presented after returning from Thailand. He had developed a tender swollen left wrist. Urine NAAT for CT/GC was negative. He reported condomless oral and vaginal sex with multiple Thai females. Gonococcal tenosynovitis was suspected and extragenital NAATs and cultures for CT/GC were taken; NAAT for pharyngeal gonorrhoea was positive. Single dose ceftriaxone and azithromycin was prescribed, followed by cefixime for 1 week. Two weeks later his symptoms cleared.

Conclusion Reflecting on these cases a DGI diagnosis was attained following careful consideration of possible differentials and persistence in identifying *Neisseria gonorrhoeae*. Both diagnoses would have been missed if following current testing guidance which recommends penile-only sampling of heterosexual men.

C3 SYPHILITIC AORTITIS IDENTIFIED IN A PATIENT NEWLY DIAGNOSED WITH HIV – THE EMERGING TIP OF AN ONCOMING ICEBERG?

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10.1136/sextrans-2015-052126.36

Background A 38 year old man presented for HIV testing following his male partner's diagnosis. Examination revealed systolic and decrescendo diastolic heart murmurs, palpable thrill, bounding pulses, and positive Corrigan's sign. He had not tested previously for HIV or syphilis and had been in a monogamous relationship for 8 years. We describe this man who was asymptomatic – from both HIV and aortic valve disease – with incidental diagnosis of severe syphilitic aortitis following partner notification for HIV.

Results HIV antibody test was positive with baseline viral load 239505 copies/ml and CD4 count 103 cell/L (8%). Syphilis serology was positive with rapid plasma reagin (RPR) 1:4. CXR was unremarkable. ECG was consistent with left ventricular hypertrophy with strain. Echo revealed severe mixed aortic valve disease, left ventricular hypertrophy, good LV systolic function and normal aortic arch appearance. He commenced prednisolone 60 mg OD for 5d, 72 hr before starting three weekly doses of 2.4 MU benzathine penicillin. He was admitted for 48 hr for cardiac monitoring at the start of treatment – which proceeded with no complication. Multidisciplinary involvement with GU physicians, cardiologists and cardiothoracic surgeons was instigated from the start with aortic valve ± root replacement planned imminently.

Discussion Resurgence of syphilis in the UK was reported in the late 1990s with an ongoing epidemic since, mainly involving MSM. Cardiovascular syphilis typically occurs 15–30 years following primary infection with *Treponema pallidum*, with complications in 10% of cases. Could this man be amongst the first cases to develop tertiary syphilis in this latest epidemic?

C4 A COMPLICATED CASE OF CANDIDA

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10.1136/sextrans-2015-052126.37

Background Vulvovaginal candidiasis (VVC) is a common condition caused by *Candida albicans* in 80–92%. *Candida robusta* is rarely identified in humans and has only been reported as a cause of VVC in pregnant women. We present a case of chronic *Candida robusta* VVC.

Case A 25 year-old, on Cerazette, presented to her GP with discharge and vulval itching; treatment with clotimazole was effective but symptoms recurred. In clinic, one month later, a clinical and microscopic diagnosis of VVC was made, she was treated with fluconazole plus econazole pessary and cream. HIV, syphillis, gonorrhoea and chlamydia were negative.

Despite initial improvement she represented with recurrent symptoms, microscopy and culture again confirmed Candida species. Following a fourth presentation oral fluconazole 150 mg every 72 h x 3 followed by a weekly dose for three months was commenced. She was asymptomatic during this time but relapsed on discontinuation. Microscopy again confirmed spores and on speciation Candida robusta sensitive to fluconazole was isolated. A second 3-month fluconazole course was given. She had now developed provoked vulvodynia. Low-grade symptoms persisted and Candida robusta was again cultured, now resistant to fluconazole. A one-week course of oral voriconazole was given. Follow-up microscopy was negative but her vulvodynia had worsened. Treatment with amitriptyline was commenced and on review two months later culture remained negative and her vulvodynia had improved.

Discussion We report a case of chronic Candida robusta VVC in a non-pregnant immunocompetant woman, which acquired fluconazole resistance and precipitated vulvodynia. Speciation and sensitivity testing are important in women with recurrent symptoms.

C5 A CASE OF REPEATED RHABDOMYOLYSIS ASSOCIATED WITH PEPSE: AN UNCOMMON SIDE EFFECT OF RALTEGRAVIR

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10.1136/sextrans-2015-052126.38

Background/introduction The first line regime for PEPSE recently changed to Truvada/Raltegravir. We report on a case of rhabdomyolysis associated with Raltegravir.

Case A 25 year old MSM requested PEPSE in February 2013. Commencing Truvada/Kaletra, he switched to Truvada/Darunavir/Ritonavir due to arthralgia. He further received Truvada/Darunavir/Ritonavir 4 months later for another PEPSE request.

A third PEPSE episode was initiated in September 2014 commencing Truvada/Raltegravir. Baseline investigations showed an eGFR 75 ml/min/1.73 m^2. Two weeks later the patient was complaining of severe myalgia/lethargy. Also he noticed his urine colour change to brown. Repeat investigations were: creatinine 121 umol/L, eGFR 62 ml/min/1.73 m^2, Creatine Kinase (CK) 1392 iu/L, urine protein/creatinine (uPCR) 2.9 mg/mmol. On urgent review he was admitted for IV rehydration and cessation of PEPSE having developed an acute kidney injury and rhabdomyolysis. His CK fell following fluid replacement.

In November our patient was seen again having self-initiated PEP following a needle-stick injury from a used needle. He had taken 1 Truvada/Raltegravir from left over medication. However he had recurring myalgia and lethargy. His repeat CK was 2625 iu/L. The regime was immediately stopped, however his muscle pains and weakness continued for 3 weeks with a slow decline in his CK.

It was thought the 2 episodes of rhabdomyolysis were drug related secondary to his PEP regime with Raltegravir.
Discussion/conclusion Myopathy and rhabdomyolysis have been reported with use of Raltegravir, our case highlights a cautionary note in a regime that will become more common place.

Undergraduate Presentations: 3rd June 2015

U1 ASYMPTOMATIC LYMPHOGRANULOMA VENEREUM IN KNOWN HIV POSITIVE MSM: IS IT MORE COMMON THAN WE THINK?

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10.1136/sextrans-2015-052126.39

Background/introduction The primary manifestation of lymphogranuloma venereum (LGV) infection in men who have sex with men (MSM) in the United Kingdom (UK) is haemorrhagic proctitis with very low levels of asymptomatic infection reported.
Aim(s)/objectives To evaluate LGV infection in MSM attending a large inner city sexual health and human immunodeficiency virus (HIV) clinic.
Methods Data was retrospectively collected on all MSM diagnosed with rectal *Chlamydia trachomatis* (CT) from 1st October 2010 to 30th June 2014. Information was collected on presentation, LGV diagnosis, HIV status, concurrent sexual infection, treatment and sexual contacts.
Results 583 MSM had a new diagnosis of rectal CT during the study period of which 173 (29.7%) were known to be HIV positive. 118 MSM (20.2%; 64 HIV negative; 54 HIV positive) underwent additional testing for LGV and 32 infections (26 HIV positive MSM) were confirmed. All asymptomatic LGV infections (n = 5; 15.6%) were diagnosed in HIV positive MSM whilst all HIV negative MSM with LGV infection were symptomatic.
Discussion/conclusion We report a higher incidence of asymptomatic LGV infection in MSM than previously reported. Whilst the number of confirmed LGV infections is low, results suggest screening for LGV infection may be appropriate in all HIV positive MSM with confirmed rectal CT regardless of symptomatology.

U2 WHAT DO MEN WHO HAVE SEX WITH MEN (MSM) TAKING POST-EXPOSURE PROPHYLAXIS (PEP) FOR HIV FOLLOWING SEXUAL EXPOSURE REPORT ABOUT THEIR RECENT SEXUAL RISK-TAKING BEHAVIOUR?

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10.1136/sextrans-2015-052126.40

Background/introduction High-risk sexual behaviour plays a significant role in the increasing incidence of HIV infection among men who have sex with men (MSM) in the UK, despite the availability of post-exposure prophylaxis following sexual exposure (PEPSE).
Aim(s)/objectives Behavioural interventions to encourage safer sexual practices need to be effective and acceptable for their target population. Therefore, this study aims to identify the attitudes and interpretation of risk of MSM taking PEPSE.
Methods Data was collected as part of an ongoing randomised controlled trial evaluating a psychological intervention in reducing risk behaviour amongst MSM prescribed PEPSE. The intervention group received two 30-minute telephone interventions implementing augmented motivational interviewing. In this study, 30 participants were selected from the intervention arm and their interventions analysed for thematic content.
Results Themes included: circumstances of event that led to PEPSE; participant's interpretation of risk; emotions associated with risk; disclosure of HIV status; value attributed to consequences of risk; and reason for seeking PEPSE.
Discussion/conclusion Risks were mostly reported in the context of unprotected anal intercourse (UAI) with casual partners, without discussion of HIV status. One theme that arose was the use of mobile-phone applications to seek casual sexual partners. Reasons given for engaging in UAI included anxiety over suggesting condom use, engaging in UAI as a form of "self-harm", and alcohol intoxication. Concern about the morbidity and stigma associated with HIV and the desire for relationships were motivating factors for avoiding HIV. PEPSE was frequently described as an insight into life-long antiretroviral therapy for HIV infection.

U3 DEMOGRAPHIC ASSOCIATIONS WITH GONORRHOEA INFECTIONS IN BRIGHTON

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10.1136/sextrans-2015-052126.41

Background/introduction Gonorrhoea is a public health problem due to rising incidence and antimicrobial resistance. Understanding drivers of infection locally is important for planning public health interventions.
Aim(s)/objectives Describe demographics, lifestyle factors and antimicrobial resistance of gonorrhoea infections in Brighton.
Methods A prospective study recruited 121 individuals with gonorrhoea. Participants completed a questionnaire and cultures underwent whole genome sequencing. Data from questionnaires and electronic records were anonymised and analysed.
Results Average age was 33.6 years, 7.4% were female, 91.3% were white, 80% were MSM, 6.3% bisexual males. 35.9% of MSM were HIV-positive. In MSM, multisite infection was common. MSM had on average 8 partners in 3 months before diagnosis, compared to 4 for heterosexuals. 71.6% reported visiting a sauna, sex party or the internet to find partners. Sex under the influence of drugs occurred in 39.1% of HIV-positive MSM, 36.4% of HIV-negative MSM and 27.3% of heterosexuals. Most commonly used drugs were mephedrone by MSM and cocaine by heterosexuals. Condom use was lowest in HIV-positive MSM. Previous STIs were more frequent in HIV-positive MSM, particularly syphilis (55% vs 9.1%). 66.9% were culture-positive. Resistance to >1 antibiotic occurred in 34.8% of HIV-positive MSM, 9.1% of HIV-negative MSM and 9.1% of heterosexuals.
Discussion/conclusion Condom avoidance, frequent partner change and sex under the influence of drugs are common in both HIV-positive and HIV-negative MSM, raising concerns about HIV transmission. Antibiotic resistance is more common in HIV-positive MSM, concurring with the national surveillance programme. Effective interventions targeting this group are needed.

U4 SIGNIFICANT BENEFIT OF A TARGETED HIV TESTING MODULE ON MEDICAL STUDENTS' KNOWLEDGE AND CONFIDENCE

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10.1136/sextrans-2015-052126.42

Background/introduction Despite national guidelines for HIV testing, this issue can be overlooked by medical school curriculums. With one quarter of HIV in the UK remaining undiagnosed, it is important the next generation of clinicians are informed appropriately.
Aim(s)/objectives Evaluate the efficacy of a TTT session introduced at a medical school.
Methods A short survey assessing knowledge of HIV testing guidelines, confidence to offer testing and outcomes of TTT was developed and distributed to fifth year medical students. Results were compared for students who had completed GU/HIV modules (GU+) and those who had not (GU-) and chi-squared testing was performed.
Results 100 and 119 questionnaires were returned by GU+ and GU- students (a response rate of 92.6% and 97.5%) respectively. For the 3 knowledge-based questions, GU+ students were significantly more likely to provide correct answers for 2 ($p < 0.001$). For the confidence questions GU+ students were significantly more likely to feel confident in offering HIV testing ($p < 0.001$). After TTT 92%, 98% and 62% felt more confident about when to test, how to discuss testing and more knowledgeable about testing, respectively. Most students said they would be happy to offer HIV testing in a variety of medical settings; significantly fewer reported this for an acute admissions unit (AAU) compared with antenatal clinic (79% vs 96%).
Discussion/conclusion GU+ students scored significantly better for 2 of 3 knowledge questions and for both confidence questions. Most students felt more confident and knowledgeable about HIV testing after TTT. Although most students were happy to offer and conduct testing, significantly fewer were confident in AAU compared with an antenatal clinic (where opt-out testing is well-established). This may warrant further exploration and consideration of context-based teaching.

U5 THE 2013–14 EUROPEAN COLLABORATIVE CLINICAL GROUP (ECCG) REPORT ON THE EUROPEAN MANAGEMENT OF THE PARTNER NOTIFICATION GUIDELINE

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Background/introduction Partner notification (PN) is a public health service in which sexual partners of individuals with sexually transmitted infections (STI's) are informed of their exposure and offered testing, treatment, and support services. Previously there has been considerable variation in PN across Europe due to a number of factors including lack of financial resources and variations in look back periods. In 2013 the European guideline on PN was published in an attempt to bring consistency across the European region.
Aim(s)/objectives To evaluate the current PN policies amongst sexual health physicians across Europe against the current European guidelines.
Methods A clinical scenario based questionnaire was developed by a panel of European experts on PN, and this was disseminated to a group of 120 sexual health physicians across 38 countries, who are members of the ECCG – a network of sexual health specialists who conduct questionnaire-based research across the European region.
Results Provisional results demonstrate wide variation in PN across Europe, with differing legal and clinical requirements. Full results will be available by the conference.
Discussion/conclusion Partner notification varies widely across Europe and is not always in line with current European guidelines. There is a need for on going Europe wide education to ensure that PN occurs and is effective to avoid reinfection of the index case, and to prevent onwards transmission of STI's, especially in an environment of rising STI rates and increased travel of people within Europe.

U7 FACTORS CONTRIBUTING TO REPEAT PEPSE IN MSM

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10.1136/sextrans-2015-052126.44

Background/introduction PEPSE is a significant tool for preventing HIV transmission among MSM. Further understanding is required on the extent and risk factors for repeat PEPSE (rPEPSE) presentations.
Aims/objectives This study aimed to determine the rate of repeat PEPSE and identify factors involved in rPEPSE presentations.
Methods MSM attending for PEPSE in Brighton, May 2009–May 2014 were included. Information was collected retrospectively on demographics, number of rPEPSE prescriptions, recreational drug and alcohol use, type of sexual exposure, condom use, mental health (MH), continued risk taking while on PEPSE, partner factors, PEPSE regime and risk reduction interventions. Data were analysed using Excel functions (Spearmann's rank correlation coefficient).
Results 929 MSM accessed PEPSE – 110 (11.5%) had repeat PEPSE prescriptions (48.2% twice, 25.5% 3×, 9.1% 4×, 7.3% 5×, 6.4% 6×, 1.8% 7×, 1.8% 8× and 0.9% 9×). rPEPSE prescriptions were associated with low condom use (25.2% used condoms), MH problems (43.9% had at least one recorded) and alcohol/recreational drug use (49.1% patients had used alcohol prior to their attendance for rPEPSE, 40% had used drugs). Those with > 4 episodes rPEPSE reported more recreational drug use (significant association: $p = 0.04$). Lower numbers of rPEPSE prescriptions (2/3) were associated with alcohol use ($p = 0.07$). 6.4% of those accessing rPEPSE became HIV positive.
Discussion/conclusion This study identified an 11.5% rate of rPEPSE among MSM in this area and highlights contributory factors to rPEPSE and could help inform behavioural and risk reduction interventions at a local level.

Poster Presentations

Category: Bacterial sexually transmitted infections

P1 USAGE OF NUCLEIC ACID AMPLIFICATION TESTS (NAAT) IN THE DETECTION OF *TRICHOMONAS VAGINALIS* IN A LOW PREVALENCE AREA

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10.1136/sextrans-2015-052126.45

Background/introduction There is a low prevalence of *Trichomonas Vaginalis* (TV) in the area where the clinics are based. Screening has been performed by wet preparations. BASHH guidelines have suggested the test of choice is nucleic acid amplification test (NAAT) where resources allow- Would a TV NAAT detect more cases?
Aim(s)/objectives To compare detection rates of TV using a wet preparation, direct fluorescence, culture and NAAT tests in symptomatic female patients.
Methods The evaluation was performed in 2 stages. In the first stage, 218 symptomatic female patients had a high vaginal swabs (HVS) taken for a wet preparation and for fluorescence and culture for TV In the second stage 126 symptomatic female patients had HVS taken for wet preparation, fluorescence, culture and a further sample for TV NAAT by two methods of real time PCR.
Results 218 patients were tested in the first stage – 218 results were negative via wet preparation as well as via fluorescence and culture. In the second stage 124 results were negative via the wet preparation compared to 125 tests via culture/ fluorescence. There were 3 tests positive via NAAT (2 were positive via wet prep/culture/fluorescence. 1 was negative via wet prep but positive via culture/fluorescence). 2 tests were inhibitory via NAAT (negative via wet prep/culture/fluorescence).
Discussion/conclusion In this sample of symptomatic patients, the TV NAAT detected less than 1% (1/124) additional positive results. We conclude that in this low prevalence area for TV, a wet preparation from an HVS is satisfactory for screening symptomatic female patients.

P2 EPIDIDYMO-ORCHITIS: UROLOGICAL CONDITION BEST MANAGED BY SEXUAL HEALTH CLINICIANS?

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10.1136/sextrans-2015-052126.46

Background/introduction Epididymo-orchitis (EO) is a common urological problem: men frequently present to the Emergency Department (ED), Urology or Sexual Health (SH). EO is caused by STIs (chlamydia and gonorrhoea) and uropathogens.
Aim(s)/objectives The aim of this study was to audit the management of EO presenting to ED, Urology and SH locally.
Methods 127 patients with EO who attended ED, Urology and SH departments between January–June 2014 were reviewed.
Results 127 men were seen (median age: 33, range: 15–79). 44 attended ED (median age: 35), 30 Urology (median age: 37), and 53 SH (median age: 31). Sexual history was documented in 32/44(72.7%) of ED, 20/30(66.7%) of Urology and 53/53 (100%) of SH patients. MSU was sent in 17/44(38.6%) of ED, 11/30(36.7%) of Urology, and 35/53(66%) of SH patients. 53/53(100%) presenting to SH had chlamydia and gonorrhoea NAAT-testing; 3 cases had chlamydia (5.7%) and none had gonorrhoea. 14/44(31.8%) of ED and 4/30(13.3%) of Urology patients were tested; none tested positive. 90.9% of ED, 93.3% of Urology and 100% of SH patients were prescribed antibiotics. 45/53(84.9%) seen in SH, 1/44(2.2%) in ED and 1/30(3.3%) in Urology were advised to abstain from sex. Partner notification was documented in 40/53(75.5%) of SH patients, but none in ED and Urology. 30/44(68.2%) of ED, 5/30(16.7%) of Urology, and 47/53(88.7%) of SH patients were followed up within 2 weeks post-treatment.
Discussion/conclusion In the absence of torsion or surgical complications requiring hospital admission it would appear to be preferable for patients to be referred to SH for management.

P3 AN AUDIT OF PHARYNGEAL *NEISSERIA GONORRHOEAE* TREATMENT AND TEST OF CURE PRACTICES

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10.1136/sextrans-2015-052126.47

Background Pharyngeal *Neisseria gonorrhoeae* infections are usually asymptomatic and often diagnosed using nucleic acid amplification tests (NAATs). This reservoir of bacteria may contribute to antibiotic resistance through recombination with pharyngeal commensal bacteria. Therefore adherence to treatment guidelines is imperative and guidelines recommend a test of cure (TOC) after treatment.
Objective To evaluate adherence to local guidelines of treating *Neisseria gonorrhoeae* pharyngeal infection and TOC results.
Methods Retrospective case note review of all male positive pharyngeal GC NAAT tests at a sexual health clinic in 2013. The treatment and TOC details were evaluated.
Results Of 133 positive NAATs, 125/133 received treatment at our clinic. 83%(104/125) received first line treatment and 74% (93/125) returned for a TOC. The mean return time for negative TOC tests was 25 ± 9 days. 3 patients remained GC NAAT positive at TOC and 2 indeterminate, at 22 ± 3 days after treatment. 4/5 received first line treatment and 1/5 received second line, due to allergy. Without further treatment, all repeat NAAT tests were negative and all five cultures did not grow *Neisseria gonorrhoeae*. All 5 were asymptomatic and denied sexual contact between treatment and TOC. None were co-infected with other STI's.
Discussion/conclusion There was a high return rate for TOC and high levels of adherence to the local treatment protocol. Those with positive or indeterminate TOC had no distinguishing features or treatment differences, compared with those who tested negative. The treatment to TOC times for both groups was beyond guideline recommendations. Repeat negative NAAT testing suggests no treatment failure in these cases.

P4 A CRITICAL COMPARISON OF THREE DIAGNOSTIC TECHNIQUES USED FOR THE DETECTION OF *TRICHOMONAS VAGINALIS* (TV)

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10.1136/sextrans-2015-052126.48

Background British Association of Sexual Health and HIV (BASHH) has recommended that nucleic acid amplification tests (NAAT) to become a gold standard method of TV detection in the 2014 guidelines.
Aims To compare the efficacy of traditional wet mount microscopy (WMM), culture and TMA (Transcription Mediated Amplification) by Aptima assay for the detection of TV in our local population. The cost effectiveness of TMA and staffing requirements will also be assessed.
Methods All female patients with vaginal discharge, male contact patients and males with persistent urethritis were included. Aptima high vaginal/cervical swabs routinely tested for chlamydia or gonorrhoea by TMA were used for Aptima TV testing, as were urines. All swabs and urine samples had WMM performed and cultured in modified diamonds media. Positivity rate, sensitivity, specificity, positive predictive value (PPV) and costs per test were calculated. The statistical significance was measured by McNemars test.
Results 436 patients were included in the study, 64 male and 372 female. 11 were positive by at least one method, including one male. All TMA positive patients were also positive by urine except for 2. There is no statistical difference between WMM and culture ($p = 0.25$) but a highly significant difference between TMA and culture ($p = 0.0124$) and TMA and WMM ($p = 0.0043$). TMA is the most expensive test at >£5 per test.
Conclusions TMA is the most sensitive test for TV. It has fast turnaround time and suitable for female urine samples. Its use is limited due to cost and suitability for other samples e.g. in male patients.

P5 GONORRHOEA AUDIT: CHANGING PATTERN OF ANTIBIOTIC SENSITIVITY AND PERSISTENCE OF DNA DETECTION 2007–2014

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10.1136/sextrans-2015-052126.49

Background Nucleic acid amplification testing (NAAT) is widely used in GUM clinics to diagnose GC infection; its in-built high sensitivity may potentially detect DNA from non-viable organisms following successful treatment. The BASHH national guidelines stipulate that test of cure (TOC) with NAAT should take place 2 weeks post treatment. The purpose of this study was to determine whether this is an adequate time interval to perform TOC. We also analysed the changing pattern of antibiotic sensitivity between 2007–2014.
Methods All GC cases at our clinic between 01/01 to 30/06 in 2007–2014 were identified and assessed for antibiotic sensitivity and TOC.
Results In 2014 there were 126 cases, culture and sensitivity results were available for 85. TOC with NAAT was done in 71 cases. There were 5 cases where the NAAT was SDA positive but not PCR, two of these had a negative NAAT when tested at 29 and 57 days post treatment. Two patients DNA for a repeat NAAT. The fifth had serial repeated NAAT SDA positive results (however original cultures were sensitive to 1st line therapy), this patient had a negative NAAT after re-treatment. There was one positive result 14 days after treatment (re-treated); the NAAT was not repeated. Overall a TOC with NAAT was performed between 7–50 days after treatment with a mean, median and mode of 18, 15 and 14 days respectively.

Abstract P5 Table 1 Gonorrhoea antibiotic sensitivities

Antibiotic resistance profiles	2007 (%)	2009 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Percentage of GC fully sensitive to antibiotic testing panel	46	67	59	49	79	59
Reduced susceptibility to 1 antibiotic group	27	15	20	38	10	20
Reduced susceptibility to 2 antibiotic groups	15	10	16	8	6	13
Reduced susceptibility to 3 antibiotic groups	12	2	5	3	2	8

Conclusion None of the cultures were resistant to ceftriaxone. Follow up with NAAT testing at 2 weeks appeared to be adequate for TOC.

P6 LOVE LETTERS – THE NOTIFICATION GAME

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10.1136/sextrans-2015-052126.50

Background In accordance with the national trend there was a perceived increased incidence of anogenital and pharyngeal gonorrhoea presenting to the sexual health (SH) department at a district general hospital (DGH) in the year March 2013–2014.
Aims and objectives To establish the incidence of gonorrhoea in our SH patient population (March 2013–2014). To ensure that the SH department was compliant with BASHH standards for the management of gonorrhoea.
Methods Retrospective audit of all confirmed cases of gonorrhoea presenting to SH at one DGH in the period March 2013–2014.
Results 79 patients were identified; all were audited. There was a high level of adherence to BASHH standards but concern regarding partner notification. Partner notification was initiated in 86% of cases, 95% were patient led. Patient led referral resulted in poor evidence of partner notification. 71% of all cases reported more than 1 sexual partner in the previous 3 months yet 57% of the total cases notified just 1 contact. 4 patients reported 10 or more contacts; only 1 patient was recorded as having notified 10 or more partners.
Discussion/conclusion Poor partner notification may be contributing to increasing gonorrhoea prevalence. It has been suggested that patients from different demographics may preferentially use different, specific communication methods for partner notification. By working with patients to individually tailor notification methods based on demographic background, notification rates may be improved. This is an approach under consideration by SH at this DGH.

P7 THE EPIDEMIOLOGY OF UNIQUE NG-MASTS DIFFERS FROM THAT OF COMMONLY CIRCULATING NG-MASTS IN LOTHIAN, SCOTLAND

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10.1136/sextrans-2015-052126.51

Background/introduction Surveillance of gonococcal infection in Scotland has demonstrated variation in the prevalence of Neisseria gonorrhoeae multi-antigen sequence types. Some appear to circulate extensively, other sequence types (STs) may be recorded only once.
Aim(s)/objectives We aimed to review the epidemiology of gonococcal infection resulting from unique STs and examine for any association between unique STs and antibiotic resistance patterns.
Methods All gonococcal isolates from Lothian with a ST unique to Scotland, identified July 2006–October 2013, were included in the study. A control group of 76 patients infected with commonly circulating STs was also identified from the same study period.
Results 92 cases of *N. gonorrhoae* with unique STs were identified. Of these, 55 were truly distinct and categorised as 'unique and different'. The remaining 33 cases had STs which differed only slightly from locally circulating types and were likely to have evolved due to mutation of common strains. These were categorised as 'unique and similar'. Patients infected with 'unique and different' STs were significantly more likely than controls ($p < 0.5$) to have had recent sexual contact outside of Europe and/or had a recent sexual partner of non-British nationality. However, they were no more likely to have a significantly altered antibiotic resistance profile, though there was a trend towards increased antibiotic resistance.
Discussion/conclusion Gonococcal strains from non-European countries may be associated with antibiotic resistance. Identification of a 'unique and different' sequence type raises the possibility of an imported strain of gonococcal infection and demands particular vigilance in looking for antibiotic resistance.

P8 WHERE DO PATIENTS GO FOR CHLAMYDIA TESTING WITHIN NON-GUM COMMUNITY SETTINGS AND WHAT PROPORTION OF RE-TESTERS SHOWS VENUE LOYALTY?

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10.1136/sextrans-2015-052126.52

Background/introduction The English National Chlamydia Screening Programme focuses on prevention, control and treatment of chlamydia in sexually active under-25 year olds. A greater understanding of where young adults attend services helps to inform commissioners of where to focus resources within community settings.
Aim(s)/objectives To investigate whether young people return to the same type of primary care / community (i.e. non-Genitourinary Medicine) service for re-testing.
Methods Surveillance data from the Chlamydia Testing Activity Dataset (CTAD) was used to identify patient attendances at primary care / non GUM community services among 15 to 24 year olds and monitor re-testing within and between community services.
Results From January 2012 to December 2013, 1,333,718 young people underwent 1,626,106 chlamydia tests. The majority of people (84%) were tested only once. Of those who tested more than once, 57% used the same venue type. General Practice (GP) was the most commonly re-attended service for patients who tested twice (55.3%). Among those who tested three or four times, there was an increasing preference for community sexual health services (50% and 57% respectively).
Discussion Patients re-attended GP services more often than other venue types but for subsequent attendances more specialised community sexual health services were used. Very few repeat visits were made to pharmacies or pregnancy termination services. These data show that patients are likely to return to services they know when they require a further test. This should be taken into consideration by commissioners implementing new retesting guidance from the NCSP.

P9 LOW FALSE POSITIVE RATE OF GONORRHOEA CASES REFERRED TO GUM FROM A LOW PREVALENCE CHLAMYDIA SCREENING POPULATION

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10.1136/sextrans-2015-052126.53

Background/introduction Recent national guidance for the detection of gonorrhoea (GC) has raised concerns that the majority of initial positive GC test results are likely to be false positives when a low prevalence population is screened using a nucleic acid amplification test (NAAT). Our local chlamydia screening programme uses a dual NAAT for chlamydia and GC and has a low reactive GC rate <1%. All GC reactive cases are referred to GUM for further investigation.
Aim(s)/objectives To determine whether GC reactive cases referred from our local chlamydia screening programme were true GC infections or likely to be false positive cases.
Methods A retrospective case notes review of 13 consecutive GC reactive cases seen at our clinic referred from the local chlamydia screening programme.
Results 10/13 were women. 10/13 cases were confirmed as true GC infections by positive genital GC cultures. In 1 case genital culture was negative but screening and supplementary NAAT with a different target confirmed a true GC infection. In 1 case genital cultures were negative however pharyngeal culture was positive indicating a true GC infection. In 1 case GC cultures were all negative but NAAT tests were reactive from genital and pharyngeal sites and equivocal from the rectum.
Discussion/conclusion Only 1/13 GC reactive cases seen in our GU referred from a low prevalence screening population might have been a false positive. Contrary to recent publications, in our area, using a dual NAAT is unlikely to lead to high numbers of false positive GC results.

P10 A MULTICENTRE ANALYSIS OF THE MANAGEMENT OF GONORRHOEA (GC)

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10.1136/sextrans-2015-052126.54

Background GC is the second most common sexually transmitted infections after chlamydia. The emergence of resistant strains has made it vital for each case to be managed according to national standards in order to reduce onward transmission.
Aim To compare the current management of GC across five centres in Essex in accordance with the British Association of Sexual Health and HIV (BASHH) auditable outcomes.
Methods 30 case notes of confirmed GC diagnosis from each centre between January–September 2013 were reviewed. Data collected included demographic, sites of infection, diagnostic methods, chlamydia testing, treatment protocol, test of cure (TOC), partner notification (PN) and health adviser (HA) referral.
Results As illustrated in Table 1. 150 cases were analysed. Most infections were acquired locally, diagnosed clinically alongside microscopy with majority isolated from the urethra in male and cervix in female. 3 resistant strains were identified. Multiple sites of infection were also observed. 143(95.0%) cases were managed in accordance with all treatment and diagnostic standards but only 84.6% had TOC, 83.8% PN and 67.7% seen a HA.

Abstract P10 Table 1 Gonorrhoea Audit

Total	150 (100.0%)
Male	95 (63.0%)
Female	55 (37.0%)
Men sex with men (MSM)	41 (27.0%)
Age	
<16	8 (5.0%)
17–24	76 (51.0%)
25	66 (44.0%)
Source of infection	
UK	138 (92.0%)
Non-UK	12 (8.0%))
Infection sites	
Throat	51 (23.0%)
Urethral	92 (42.0%)
Cervix	41 (19.0%)
Rectum	33 (15%.0)
Chlamydia testing	143 (95.0%) 31(22.0%) positive
BASHH guidelines adhered to TOC at 2/52	143 (95.0%)
	104 (73.0%)

Conclusion Almost all GC cases in the region were well managed. However TOC, PN and HA referral standards were not met likely due to lack of resources and poor documentation.

P11 DECLINING RATES OF CHLAMYDIAL RELATED EPIDIDYMITIS IN MEN AGED 15–35 YEARS: A REVIEW OF SURVEILLANCE DATA FROM ENGLISH GENITOURINARY MEDICINE CLINICS, 2009–2013

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10.1136/sextrans-2015-052126.55

Background Monitoring trends in chlamydia-related sequelae, such as epididymitis and pelvic inflammatory disease (PID), is an important aspect of the evaluation of chlamydia control initiatives such as the National Chlamydia Screening Programme (NCSP). Unlike PID, which can be difficult to diagnose, epididymitis may be a useful measure for evaluation purposes. The objective of this analysis was to examine trends in epididymitis diagnosis rates in the era of increased chlamydia testing.
Methods Diagnoses of epididymitis among 15–35 year old males were obtained from the genitourinary medicine (GUM) clinic activity dataset version 2. Diagnosis rates were calculated, per year, using the number of new-episode male clinic attendances. This accounted for changes in clinic attendance over the years. Negative binomial regression was used to derive the incidence rate ratios (IRR) and test significance of the trends.
Results Between 2009 and 2013, a total of 24,689 diagnoses of epididymitis were made among 15–35 year old males, of which 10% (2,506) were of chlamydial and 2% (473) of gonoccocal aetiology. Diagnosis rates of chlamydial epididymitis declined by an average of 12% per year (IRR = 0.88, 95% CI; 0.81–0.96, $p < 0.001$), while no statistically significant changes were observed in rates of gonoccocal epididymitis (IRR = 0.93, 95% CI; 0.86–1.00 $p = 0.276$). A small but significant decline of 2% per year (IRR 0.98: 95% CI; 0.96–0.99, $p = 0.001$) was observed for rates of non-specific epididymitis.
Conclusion The decreased rate of chlamydial epididymitis diagnoses in men may be associated with increased chlamydia testing, however, the influence of other contributing factors should be explored.

P12 MANAGEMENT OF ACUTE EPIDIDYMO-ORCHITIS: AD HOC OR EVIDENCE BASED?

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10.1136/sextrans-2015-052126.56

Background/introduction A clear guideline exists for the management of acute epididymo-orchitis. Both the EAU and our local trust antibiotics guidelines state that patients aged 35 or younger, or those with suspected STI, be prescribed single dose ceftriaxone with a course of doxycycline; while patients over 35 receive ciprofloxacin. All patients should be investigated for an STI.
Aim(s)/objectives This study looks at how the guidelines are being implemented in the accident and emergency (A&E) department of a large teaching hospital.
Methods We reviewed the A&E notes of patients attending the department with suspected epididymo-orchitis between 1st May and 28th October 2014. 56 patients' notes were scrutinised for a record of sexual history, investigations performed and final management.
Results Of the 56-patient study cohort, 20 were aged 35 years (median age 51; range 36–84 years) and 36 >35 years (median age 25; range 20–34 years). A sexual history was documented in 26 (46%) cases, with one patient tested for presence of STI and six (10%) advised to visit the GUM clinic. Antibiotics were prescribed for 55 patients; 28 (50%) received ciprofloxacin (mean age 53.5, range 21–91 years), two (aged 25 and 27 years) doxycycline, 13 (23%) both ciprofloxacin and doxycycline (mean age 36.5, range 20–63 years), and 12 (21%) received different antibiotics (mean age 50.8, range21–83 years). 17 patients (30%) were prescribed antibiotics correctly according to the guideline.

Discussion/conclusion Despite a robust and clear guideline on epididymo-orchitis our results show that antibiotic prescribing is often incorrect. Furthermore, the work-up for an STI as a cause of epididymo-orchitis is incomplete.

P13 WHAT TO DO IN A SYPHILIS OUTBREAK

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10.1136/sextrans-2015-052126.57

Background/introduction In Autumn 2014 a surprising number of patients were being diagnosed with early syphilis, in the sexual health clinic, Reading. From January 2014 to January 2015 twenty-one early syphilis cases arose. Whereas 2013 totalled 5 cases, which was an average year.
Aims/objectives To identify if this constituted an outbreak. Determine why increasing numbers of early syphilis were arising and which patients groups were at risk. To prevent further cases.
Methods January to September cases were reviewed retrospectively and then new cases prospectively. Public Health England was notified and an action meeting ensued. Patient behaviours and contact tracing data collected. Letters written to inform healthcare services. Clinic information boards and website updated. Social media and appropriate charity organisations approached to reach target groups.
Results Eight presented with primary syphilis, ten with secondary and three with early latent. Eighteen cases were men who have sex with men (MSM), highlighting the main at risk group. Seven of the MSM were HIV positive with three being newly diagnosed. The average number of sexual contacts was twelve with one third using social networking apps to meet.
Discussions/conclusions Syphilis outbreak confirmed. MSM patients are the main risk group with one third HIV co-infection, which is a concern. Common usage of social networking apps identified to meet sexual partners, which can involve serosorting. Collaboration between sexual and Public Health teams resulted in raising awareness. Hopefully these measures will reduce the number of cases but it will require close monitoring.

P14 TESTING FOR PHARYNGEAL GONORRHOEA IN WOMEN: AN IMPORTANT RESERVOIR OF INFECTION, OR EXCESSIVE FALSE POSITIVE DIAGNOSES

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10.1136/sextrans-2015-052126.58

Background In 2012 we reported that 30% of heterosexual women attending our service had a positive gonorrhoea (GC) NAAT on pharyngeal sampling, without infection elsewhere. A PPV of 87% has been reported for our pharyngeal samples, but confirmatory GC NAATs remain routinely not available locally. Due to concerns about false positives, we subsequently restricted pharyngeal testing to women at higher risk of infection at this site only and reviewed the findings.
Methods All positive GC NAATs in women attending our service from October 2013 to March 2014 were reviewed. Findings were compared to the data from January to July 2012. All NAATs were performed on Roche Cobas 4800.
Results There were 36 women in the 2014 sample, compared to 40 in the 2012 sample. Of these, 19 (53%) had a positive GC NAAT on a pharyngeal sample, compared to 17 (43%) in the 2012 sample ($p = 0.38$). 13 (36%) of women with a positive GC NAAT had the infection detected on pharyngeal swab only in the 2014 sample, compared to 12 (30%) in the 2012 sample ($p = 0.56$).
Discussion By restricting testing to women at higher risk of pharyngeal only infection, we found 36% women had an isolated positive pharyngeal GC NAAT, and would not have been diagnosed if pharyngeal sampling was not taken. Further work is needed assessing the performance of the Roche Cobas 4800 in this population in order to evaluate the proportion of false positive diagnoses versus the extent of this potential reservoir of infection.

P15 AORTITIS REQUIRING CARDIOTHORACIC SURGERY IN A CASE OF SECONDARY SYPHILIS

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10.1136/sextrans-2015-052126.59

Background/introduction Cardiac complications of syphilis typically occur 10–30 years after being infected. There has been a recent case of aortitis in secondary syphilis in the literature.
Aim(s)/objectives To report a case of syphilitic aortitis in a patient recently infected with syphilis.
Methods Case report.
Results A 37-year-old white British female was found wandering the streets semi-clothed by paramedics. Background: bipolar/schizoaffective disorder with previous psychosis and known substance misuse. A loud early diastolic murmur was found on examination. An ECG revealed anterior T wave changes. Troponin was >2000 ng/L and echocardiogram (ECHO) revealed a dilated left ventricle with severe aortic regurgitation (AR). Transoesophageal ECHO demonstrated an oedematous, thickened aortic root. CT aortogram confirmed aortitis. Syphilis serology was positive (RPR 1:256). She had a male partner of 5 years and had never had a syphilis test before. Due to penicillin allergy she was commenced on Doxycycline for 28 days with adjuvent. Three weeks into treatment she developed heart failure and was admitted to intensive care. ECHO revealed an ejection fraction of 30% and progressive valvular pathology. Following desensitisation she commenced on benzylpenicillin plus probenacid for 17 days. Two weeks into treatment she underwent an aortic valve replacement and coronary artery bypass graft (x2). After a protracted recovery she was discharged two months later and remains under cardiology follow up.
Discussion/conclusion Whilst it is not exactly clear when this patient acquired syphilis the high RPR titres suggest that infection was recent. This case demonstrates a rare but serious and life-threatening complication of early syphilis.

P16 LGV-AN INNER CITY COHORT

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10.1136/sextrans-2015-052126.60

Background/introduction LGV is hyperendemic amongst MSM in the UK. There is a strong association with HIV and hepatitis C infections.

Aim(s)/objectives To assess the background, demographics, presentation and follow up of patients with confirmed LGV infection in an inner London cohort. To analyse compliance with BASHH auditable measures surrounding follow up testing including HIV and hepatitis C.
Methods A retrospective case note review was conducted of all PCR confirmed LGV infections from 01.01.2005–31.07.14. Data was extracted looking at the demographics, presentation, risk factors, concurrent STIs and follow up of patients as per BASHH audit standards.
Results 44 patients were identified. 43 were MSM and 1 a heterosexual female with a bisexual partner. 80% (35) presented with symptomatic LGV infection and 20% (9) had had a previous infection with LGV. 43% (19) were diagnosed with concurrent STIs; of which only 4 had extra rectal chlamydia (3 urethral and 1 eye). 64% (28) were known to be HIV positive at LGV diagnosis. Only 69% (11) of the remaining HIV negative patients had a documented HIV follow up test within 12 months of LGV diagnoses. 36% (4) of these were newly diagnosed with HIV. Out of the 24 documented hepatitis C tests within 12 months of LGV diagnosis there were 2 new cases of hepatitis C.
Discussion/conclusion Our cohort largely reflects the UK epidemic and reinforces the strong association with HIV infection. The audit reveals poor adherence to BASHH standards for repeat testing, which will be addressed with a specific active recall process.

P17 ENHANCED SEXUAL HEALTH SERVICES IN COMMUNITY PHARMACIES – PILOT

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10.1136/sextrans-2015-052126.61

Background/introduction STI screening via community pharmacies (CPs) has traditionally been very low.
Aim(s)/objectives To increase STI screening in young people (15–24 years) in a London Borough with high rates of infection using a new self-test kit (testing for Chlamydia and Gonorrhoea (CT/GC), and HIV) alongside condom distribution via the pan-London condom scheme.
Methods Nine CPs were selected based on high rates of Emergency Contraception provision and condom distribution in 2013. Frontline staff were trained and care pathways established. Ongoing monthly support was provided by site-visit and phone. Results were notified by text. Positive results, partner notification and follow-up were managed by a Level 3 GUM clinic. Evaluation was by user/CP survey.
Results

- 8 CPs were active during the pilot which ran January–December 2014.
- 214 self-test kits were distributed; 108 CT/GC tests and 96 HIV tests were returned/tested (return rates of 50.5% and 44.9% respectively). At the start 1 CP removed HIV tests from packs.
- 4,476 condoms were distributed.
- 7 Chlamydia positives were identified (positivity 6.5%).
- Quarter 1 2014 saw a 700% increase in numbers of STI tests processed) in the 9 CPs compared to Quarter 3 2013 (pre-pilot levels). This significantly increased activity continued throughout 2014.
- All users were very or quite satisfied with the service and were very or quite likely to use the service again.
- 66% were very likely to recommend the service to others

Discussion/conclusion With adequate training and support, community pharmacies provide an engaged, accessible and convenient venue for STI testing (including HIV) and condom distribution.

P18 EXPLORING QUANTITATIVE RELATIONSHIPS BETWEEN SEROLOGICAL RESULTS AND STAGE OF SYPHILIS

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10.1136/sextrans-2015-052126.62

Background/introduction There has been little published regarding quantitative results of newer serological assays in infectious syphilis. Previous studies have shown an association between VDRL and TPPA titre and stage of syphilis; with higher titres in secondary syphilis.
Aim(s)/objectives To examine quantitative relationships between serological results and stage of syphilis including newer assays.
Methods Early syphilis cases diagnosed March 2011–August 2014 were identified from a sexual health clinic database. Cases classified as primary, secondary and early latent by clinical diagnosis. Serology results were recorded including TPPA, VDRL (used until 01/03/2012), RPR (used from 01/03/2012), IgG (Abbott Architect Total Antibody Test), and IgM (lab21 IgM EIA).
Results 155 patients included. 149 male, 6 female. Average age 38. 92% men were MSM. 32% HIV positive. 33% classified as primary, 21% secondary, 46% early latent. 64% new diagnoses, 36% re-infected.

Abstract P18 Table 1 Syphilis stage and serology

	RPR (n = 110) Median (range)	VDRL (n = 45) Median (range)	TPPA (n = 155) Median (range)	IgM (n = 122) Mean	IgG (n = 155) Mean
Primary	4 (0–64)	4 (0–64)	2560 (0- >5120)	4.06	20.44
Secondary	32 (4–128)	64 (16–256)	>5120 (2560- >5120)	10.09	37.28
Early Latent	8 (0–128)	16 (0–512)	5120 (40- >5120)	3.84	29.58

Discussion/conclusion Results confirmed the quantitative relationship between syphilis stage and VDRL and TPPA titre identified previously. Additionally this study showed that IgM and IgG values, using Lab 21 IgM EIA and Abbott Architect Total Antibody Test assays, are also linked to stage of syphilis. Unsurprisingly, IgG titres were highest in secondary and lowest in primary syphilis. IgM values were lowest in early latent and highest in secondary syphilis.

P19 MEASURING THE IMPACT OF SUPPLEMENTARY TESTING OF NEISSERIA GONORRHOEA POSITIVE NUCLEIC ACID AMPLIFICATION TESTS ON THE RATE OF EXTRA-GENITAL NEISSERIA GONORRHOEA DIAGNOSIS AND CONCORDANCE OF NAATS WITH BACTERIAL CULTURE

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10.1136/sextrans-2015-052126.63

Background/introduction Nucleic-acid amplification tests (NAATs) are more sensitive in the detection of Neisseria Gonorrhoea (NG)

than culture or microscopy, but specificity at extra-genital sites may be lower due to cross reactivity with other Neisseria species. BASHH recommends supplementary testing of NG positive extra-genital NAATs to improve specificity. This inner city DGH introduced supplementary testing on 01/11/13.
Aim(s)/objectives To evaluate the impact of introducing supplementary testing on the rate of extra-genital NG diagnosis and concordance of positive NAATs with culture.
Methods All patients with a diagnosis of NG at any site between 01/08/13 and 31/01/14 were identified. Concordance of positive NAATs with bacterial culture pre- and post-intervention was reviewed.
Results There were 471 positive NAATs from 372 patients during the study period. Extra-genital samples accounted for 48.6% (n = 118/243) of positive NAATS pre-intervention and 41.2% (n = 94/228) post-intervention, (p = 0.03). Culture was obtained from 305 sites, 119 of which were extra-genital. Concordance pre- and post-intervention is detailed in below.

Abstract P19 Table 1 Gonorrhoea test concordance

	Proportion of cultures positive for NG		
	Pre intervention	Post intervention	*P* value
Rectal	9/21 (42.8%)	10/19 (53.0%)	0.39
Pharyngeal	3/49 (6.10%)	3/31 (9.67%)	0.40

Discussion/conclusion The proportion of NG positive NAATs from extra-genital sites fell following the introduction of supplementary testing, which may reflect an improvement in specificity. A non-significant increase in concordance of NAATs with culture was noted however concordance was low overall, especially in the pharynx. It remains unclear whether discordant results represent lower sensitivity of culture, lower specificity NAATs despite supplementary testing, or spontaneous clearance between screening and recall for culture.

P20 INVESTIGATION INTO AN INCREASE OF DIAGNOSES OF GONORRHOEA IN SOUTHEND-ON-SEA

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10.1136/sextrans-2015-052126.64

Background/introduction Between 2012 and 2013 the rate of gonorrhoea in Southend increased significantly from 24.6 to 42.4 per 100,000. A multidisciplinary Incident Management Team was established in June 2014 to assess the situation and implement appropriate control measures. However, the number of cases had already begun to fall. A retrospective case review was initiated.
Aim(s)/objectives To identify factors that contributed to the increase and subsequent decrease in diagnoses.
Methods Enhanced questionnaires were completed for each case diagnosed between October 2012 and March 2014. Antibiotic resistance profiles were provided by the local laboratory. Previous STI and HIV test history was extracted from the Genitourinary Medicine Clinic Activity Dataset (GUMCADv2).
Results Provisional results show that enhanced forms were completed for 160 cases. Majority of cases were of white ethnicity (64%) and born in the UK (87%). Cases were aged between 15 to 63 years (median 28 years), 62% were male and 60% heterosexual. Most cases had 1 or 2 partners in the preceding 3 months and attended because of symptoms (40%). However, approximately 30 cases had been referred from a level 2 service – some of which had negative results when re-tested. The majority of cases were treated with first line therapy and had a test of cure undertaken.
Discussion/conclusion Full details of the epidemiology, presentation and diagnosis of the cases will be presented – including a comparison with the cases diagnosed before and after the increase, the use of social network techniques and an analysis against the auditable outcome measures in the BASHH guidelines.

P21 IS IT SYPHILIS? THE DARK ART OF INTERPRETING SYPHILIS SEROLOGY

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10.1136/sextrans-2015-052126.65

Background/introduction The diagnosis of syphilis relies mainly upon a panel of serological tests. A sensitive treponemal test such as the enzyme immunoassay (EIA) is used as a screening test; another treponemal test such as the *Treponema pallidum* particle agglutination (TPPA) assay is used to confirm a reactive screening test. Difficulties arise when these tests produce a discordant result. Our laboratory uses the INNO-LIA immunoblot assay to resolve discordant screening results.
Aim(s)/objectives To evaluate whether the use of the INNO-LIA enables clinically useful interpretation.
Methods We reviewed the last 100 INNO-LIA tests performed by our laboratory.
Results Comparison of EIA, TPPA and INNO-LIA results are shown in Table 1. The Antibody Index is a measure of the positive signal in the EIA (1.2 is a positive result).
Discussion/conclusion In EIA positive (AI 5)/TPPA equivocal cases the INNO-LIA was always positive or equivocal, consistent with treponemal infection. The INNO-LIA test may be unnecessary in these cases. In EIA positive/TPPA negative cases, the INNO-LIA is able to resolve the discordant result less than half of the time. Overall the INNO-LIA produced equivocal results in 44% of serums, which is unsatisfactory for confirming the diagnosis of syphilis. Although the INNO-LIA does help resolve some cases, there remains a need for new diagnostics.

Abstract P21 Table 1 Comparison of discordant results

No. of samples	EIA	EIA Antibody Index (AI)	TPPA	INNO-LIA			Discordant result resolved?
				Negative	Positive	Equivocal	
41	Positive	5	Negative	5	12	24	41%
30	Positive	5	Equivocal	0	20	10	100%
26	Positive	5	Equivocal	5	13	8	81%
3	Positive	5	Negative	1	0	2	33%

P22 ARE WE USING THE BEST TESTS TO DIAGNOSE TV IN GUM CLINICS IN THE UK?

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Background The Aptima TV NAAT test has been approved for use for the detection of *Trichomonas vaginalis* (*TV*) and is more sensitive (~100%) than wet mount microscopy (50%) or culture (75%). Asymptomatic women attending GUM clinics are often not tested for TV as the prevalence is assumed to be too low for testing to be cost effective.
Aims To determine

- TV positivity rate among GUM attendees with and without symptoms
- How many additional cases are identified with the new test
- Whether self-taken vaginal swabs are of equivalent sensitivity in symptomatic GUM patients.

Methods Patients were tested using the Aptima TV NAAT alongside existing testing methods. Test performance was compared using the McNemar test.
Results The positivity of TV determined by TV NAAT was 4.2% (22/519) in symptomatic and 1.8% (28/1599) in asymptomatic women. 9/20 NAAT positive patients, where all test were performed, would not have been identified on wet prep or culture. Overall TV NAAT outperformed currently used methods (p = 0.004), clinic wet prep vs NAAT (p = 0.038), culture vs NAAT (p = 0.002). Self-taken vaginal swabs were equivalent in sensitivity to clinician taken swabs; of patients who tested positive on either NAAT test, 19 tested positive on self-taken swab and 17 tested positive on clinician taken swab (p = 0.625).
Conclusions Testing all women attending GUM clinics with the APTIMA TV NAAT test will identify additional cases and is therefore likely to be cost-effective, and should be considered to replace conventional microbiological testing methods.

P23 INVESTIGATION OF THE ECONOMIC IMPACT OF IMPLEMENTING NATIONAL GUIDELINES TO RETEST YOUNG PEOPLE (AGED 16–24) WHO TEST POSITIVE FOR CHLAMYDIA

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10.1136/sextrans-2015-052126.67

Background The National Chlamydia Screening Programme (NCSP) updated its guidelines in 2013 to recommend retesting for all chlamydia positive individuals around three months after treatment, due to the risk of reinfection.
Objectives Investigate the impact of implementing new retesting guidance on chlamydia screening activities and the economic cost of updating current testing practice.
Methods We developed a spreadsheet tool to calculate the additional costs of implementing new retesting guidance. We collected data from pilot evaluations of retesting to estimate the number of tests performed and the cost of administering retesting within existing services. We used these to estimate the national impact of the new guidelines, and to inform future updates to guidelines.
Results The baseline scenario is based on findings from pilot evaluations: for every 10,000 chlamydia tests, this will generate 750 positives (assuming 7.5% positivity), of whom 40% (300) would be retested within 6 months. This would identify an additional 30 positives (10% positivity at retest). In this scenario, only 3% of all tests performed are retests, which would have minimal impact on the overall cost of the screening programme. The slight increased cost of retesting, associated with active recall of positive individuals is offset by the higher positivity observed at retest.
Conclusions The new guidelines to retest chlamydia positive individuals within 6 months appear feasible within the context of current programmes and will identify individuals at continued risk of infection with relatively low resource and time input.

P24 OUTBREAK OR ILLUSION: CONSEQUENCES OF "IMPROVED" DIAGNOSTICS FOR GONORRHOEA

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10.1136/sextrans-2015-052126.68

Background/introduction The service introduced gonorrhoea nucleic acid testing (NAATs) using the BD Viper LT™ System in August 2012. Since then rates of gonorrhoea have increased threefold (Table 1). Concerns were raised by Public Health England in 2014 that this increase represented an outbreak.

Abstract P24 Table 1 Gonorrhoea rates

	% all males	% MSM	% all females
July–Dec 2011	40/4789 (0.8%)	11/283 (3.9%)	7/5546 (0.2%)
Jan–June 2012	43/4783 (0.9%)	15/249 (6%)	18/5474 (0.3%)
July–Dec 2012	89/5002 (1.8%)	50/377 (13.2%)	17/5499 (0.3%)
Jan–June 2013	94/4957 (1.9%)	60/525 (11.4%)	25/5445 (0.4%)
July–Dec 2013	102/4838 (2.0%)	63/557 (11.3%)	42/5702 (0.7%)
Jan–June 2014	115/5221 (2.2%)	N/A	53/5936 (0.8%)

Aim(s)/objectives To ascertain if there was an outbreak.
Methods We reviewed all 153 gonorrhoea (GC) cases seen from January to June 2014.
Results Of 45 female cases, 16 (36%) were not known GC contacts, and were culture negative: all were NAATS positive at the cervix. Of 43 cases in heterosexual men, 4 were positive by NAATs only and not known contacts of GC: one had a single partner who tested negative for GC. There were 65 cases in MSM. Of 36 (55%) NAATS positive only who were asymptomatic and not a known GC contact, 32 had isolated pharyngeal infection, 3 rectal infections only and 1 dual rectal and pharynx infection.
Discussion/conclusion At an incident control meeting with the local authority, PHE and local GUM service, it was agreed there was insufficient evidence to confirm a cluster of cases and that at least some of the increase could be attributable to the introduction of NAATs testing. It was agreed to prospectively audit GC cases, until March 2015 and to send NAAT positive/culture negative samples to reference laboratory for confirmatory testing. Initial results from the first 2 months suggest that a significant number of cases are not confirmed. The full data will be

presented and the implications for GC testing in our clinic population discussed.

P25 INVESTIGATING FACTORS FOR INCREASED GONORRHOEA RE-INFECTION IN MSM ATTENDING A GU CLINIC: A QUALITATIVE STUDY

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10.1136/sextrans-2015-052126.69

Background/introduction In 2013, 63% of gonorrhoea infections in England were in men who have sex with men (MSM), in whom the annual incidence increased by 26% (PHE). In our clinic, annual incidence increased by 28.8% (2013) and re-infection (a second infection within 1-year of initial infection) rose from 6.7% as a proportion of total infections (2009) to 19.4% (2013). This is concerning given increasing reports of antibiotic resistant gonorrhoea.
Aim(s)/objectives The aim of this study was to explore reasons for repeat gonorrhoea infections among MSM.
Methods We interviewed 16 MSM about knowledge of gonorrhoea, attitudes to safe sex and antibiotic resistance.
Results Mobile applications were used to meet casual sex partners and arrange impromptu group-sex parties with partner anonymity making contact tracing difficult. The use of recreational drugs was widespread and could result in unsafe sexual practices. Participants felt their behaviour was unlikely to change despite knowing there was increased gonorrhoea prevalence and frequently felt resigned to repeat infections. Participants thought global antibiotic resistance was concerning, but felt behaviour would change only if there was local evidence of this. It was highlighted that new technologies could increase awareness around local STI trends and services for those at risk.
Discussion/conclusion MSM's use of geosocial networking applications to arrange sex could also be harnessed to increase awareness and advertise testing opportunities. Enhanced interventions at initial diagnosis may also be beneficial. In some cases risk-taking behaviours are unlikely to change and for these men regular sexual health screens should be encouraged.

P26 HOW VALUABLE IS LUMBAR PUNCTURE IN THE DIAGNOSIS OF NEUROSYPHILIS?

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10.1136/sextrans-2015-052126.70

Background/introduction UK syphilis incidence is rising. There are no national data on neurosyphilis prevalence. The CDC defines confirmed neurosyphilis as positive CSF VDRL at any syphilis stage and presumptive neurosyphilis as non-reactive CSF VDRL, raised CSF protein or WCC, positive serum VDRL and clinical symptoms/signs of neurosyphilis in the absence of any other causes. VDRL and RPR perform the same function; however, sensitivity of VDRL in CSF is poor (30–70%) and RPR even poorer.
Aim(s)/objectives To identify and characterise patients referred and treated for neurosyphilis in a London HIV/GUM service.
Methods We reviewed all cases referred for investigation of possible neurosyphilis September 2012–September 2014.
Results 1615 new diagnoses of syphilis were identified. 34 were referred for suggestive symptoms. 24(71%) were treated although only 6(25%) met CDC criteria for confirmed or presumptive neurosyphilis. Of those treated, 67% were HIV+, 4 had positive RPR (2 had no other CSF abnormality), 10 had positive TPPA only and 3 had no CSF abnormality.
Discussion/conclusion No single laboratory test is both sensitive and specific making diagnosis challenging. CSF interpretation may be particularly difficult in HIV+ individuals as HIV itself can cause pleocytosis and elevated protein concentrations. Conversely, Marra *et al*. showed that in 32% of HIV+ patients with neurosyphilis, the only CSF abnormality was a positive VDRL. We suggest that given the poor sensitivity of CSF RPR, and that CSF may be normal in neurosyphilis, most decisions to treat for neurosyphilis should be based on clinical symptoms/signs rather than CSF findings.

P27 EXTRA-GENITAL CHLAMYDIA TESTING IN HETEROSEXUAL PATIENTS. IS IT WORTH IT?

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10.1136/sextrans-2015-052126.71

Background/introduction Current clinic policy is to offer extra-genital testing to all patients reporting a history of active oral sex and/or receptive anal sex. These swabs are analysed using the Aptima Combo II platform for *Chlamydia trachomatis* (CT).
Aim(s)/objectives With analysis costing £6.20 per swab we sought to explore the cost effectiveness and review positive case with collateral contact information and symptoms history to support a positive diagnosis.
Methods Inclusion criteria were heterosexual patients with exclusively extra-genital CT who did not present as CT contact. We performed retrospective case note review of 63 sets of notes to determine symptom history, concurrent STI diagnosis and contact diagnosis.
Results Over the year, a total of 12076 throat swabs were sent in this group. There were 39 confirmed positive results giving swabs sent per positive result ratio of 310:1. Or a cost of £1922 per positive result. For rectal swabs; a total of 1156 were sent. There were 24 positive results giving swabs sent per positive result ratio of 48:1, or a cost of £297.60 per positive result. 5% of patients with a positive extra-genital swab result gave a history of throat or rectal symptoms. 4% had a concurrent STI diagnosis, 40% of those with traceable contacts had at least one positive contact.
Discussion/conclusion Routine extra-genital screening is costly but this review demonstrates its value for detection of individual cases which would have been missed. In addition the high proportion of positive contacts adds weight to the debate for extra-genital testing of all contacts.

P28 EXTRA-GENITAL GONORRHOEA TESTING IN HETEROSEXUAL PATIENTS. IS IT WORTH IT?

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10.1136/sextrans-2015-052126.72

Background/introduction Current clinic policy is to offer extra-genital testing to all patients reporting a history of active oral

sex and/or receptive anal sex. These swabs are analysed using the Aptima Combo II platform, for Neisseria gonorrhoea (GC).
Aim(s)/objectives With analysis costing £6.20 per swab we sought to explore cost effectiveness, review culture results and partner notification results.
Methods Inclusion criteria were heterosexual patients with exclusively extra-genital GC who did not present as a contact of GC. We performed a retrospective case note review of 54 sets of notes asserting symptom history, concurrent STI diagnosis, culture results and any positive contacts.
Results Over the year, a total of 13123 throat swabs were sent. There were 50 confirmed positive results giving swabs sent per positive result ratio of 262:1, or a cost of £1624.40 per positive result. For rectal swabs; a total of 1362 were sent. There were 4 positive results (all female) giving swabs sent per positive result ratio of 341:1, or a cost of £2114.20 per positive result. 2% of patients with a positive extra-genital swab result gave a history of throat or rectal symptoms. 18% had a concurrent STI diagnosis, 0% had a positive culture result from the same site. 6% had at least one subsequent positive contact, all of which were pharyngeal positive.
Discussion/conclusion Extra-genital testing has detected cases which would otherwise have been missed with purely genital screening. However numbers are too small to advocate a change in practice to routine extra-genital screening in all asymptomatic individuals.

P29 AUDIT OF RE-TESTING AND REINFECTION IN LONDON MEN WHO HAVE SEX WITH MEN WITH ACUTE STIS IN A LARGE GUM OUTPATIENT CLINIC

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10.1136/sextrans-2015-052126.73

Background Men who have sex with men (MSM) in the UK are at relatively high risk of acquiring new STIs. The British Association of Sexual Health and HIV recommend active recall of MSM diagnosed with sexually transmitted infections (STIs) for retesting after 3 months.
Objectives An audit was undertaken to assess the incidence of bacterial STIs, and rates of re-screening and re-infection amongst MSM attending a large genitourinary (GU) outpatient clinic in London.
Methods A retrospective audit of GU coding data on MSM attendees aged >18 years between January and December 2014 was performed. Data was collected on patient demographics, STI tests performed and diagnoses.
Results 397 MSM were diagnosed with 826 new bacterial STIs during the audit period (762 STIs over 534 episodes occurred in the initial 9 month period). 145 (37%) patients were HIV infected. In 98/534 (18%) episodes, a repeat screen was performed within 3 months (excluding screening within the initial 6 weeks after an STI was diagnosed); in 21 (21%) of these episodes, a further 1 STI was diagnosed. Overall, the mean time to re-screening during the study period was 108 days (excluding initial 6 weeks; range 43–282). In 149/534 (28%) of STI episodes, no repeat STI screen was performed within the period analysed.
Conclusion The incidence of STIs and re-infection in this high risk group is high, however prompt re-screening rates are low, highlighting the need for active recall. Routine 3 month text recall of MSM with an STI has since been implemented.

P30 GONORRHOEA: A RISING TIDE

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10.1136/sextrans-2015-052126.74

Background The prevalence of gonorrhoea in England increased by 15% between 2012 and 2013. In contrast, there was a 62% rise in gonorrhoea in our local area in the same time period.
Aim To identify potential areas for management improvement that may help reduce infection rates.
Methods A retrospective case note review of positive patients between 1st January and 30th June 2013 was conducted. Positive agar-based gonococcal culture or BD ProbeTec™ GC Q*x* Amplified DNA Assay results were included.
Results The 201 individuals reviewed had a mean age of 24 (range 16–53). 53% were male, 80% Caucasian and 89% heterosexual. There was no geographical postcode pattern seen. 100% resolution of infection at test of cure (TOC) was achieved in the 39% that attended. 10% TOC attendees became re-infected. 100% received Partner Notification (PN), of whom 45% had contacts attending for treatment and 36% declined to provide contact details.
Discussion Unlike the epidemic elsewhere in the UK, our outbreak is predominantly amongst male and female heterosexuals. As the majority were in the age range 16–25, targeted screening and health promotion could be delivered using the same resources as the National Chlamydia Screening Programme locally. TOC attendance was poor and the use of automatic text reminders and TOC postal kits maybe beneficial. The quality of information provided for PN can be improved with novel methods of non-standard PN. The high re-infection rate suggests a large reservoir of undiagnosed disease in our local population which needs addressing on a larger public health basis.

P31 DIFFERENCES IN DISTRIBUTION OF PLANTAR SKIN RASH OF SECONDARY SYPHILIS AND KERATODERMA BLENORRHAGICA

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10.1136/sextrans-2015-052126.75

Background/introduction Textbooks commonly assert that the most important cause of plantar skin rash is secondary syphilis (2°Syph), but there are many other possible differentials, the principal alternative STI diagnosis being keratoderma blenorrhagica (KB).
Aim(s)/objectives Observational study to quantify differences in distribution and character of plantar rash caused by 2°Syph or KB.
Methods We sourced colour photographs of confirmed 2°Syph and KB from personal slide collections, illustrated textbooks and online academic websites, checked for evidence of correct diagnosis and showing at least 80% of the full plantar surface. Lesion distribution was categorised between either the weightbearing ball and heel or non-weightbearing arch of the foot with gradations shown in the Table 1.
Results We found 50 images of 2°Syph and 25 of KB with reliably attributable clinical diagnoses. The overwhelming majority of 2°Syph lesions were entirely or almost entirely (42/50) confined to the non-weightbearing arch of the foot: Conversely KS lesions were almost all (18/25) distributed over the thicker weightbearing areas.

Abstract P31 Table 1 Distribution of lesions

	KBlenorrhagica	2°Syphilis
100% Weightbearing	10/25 (40%)	0
>90% Weightbearing	8/25 (32%)	0
>70% Weightbearing	5/25 (20%)	0
Other/Mixed	2/25 (8%)	5/50 (10%)
>70% Non-Weightbearing	0	7/50 (14%)
>90% Non-Weightbearing	0	12/50 (24%)
100% Non-Weightbearing	0	30/50 (60%)

Discussion/conclusion The plantar rash of 2°Syph is probably seen mostly in thinner areas of arch-of-foot epithelium because vasculitis is hidden under the thickly keratinised weightbearing sole. Any rash covering both areas must raise the possibility of an alternative or double diagnosis or an especially florid presentation.

P32 SURVEY OF KNOWLEDGE ABOUT GONORRHOEA IN PATIENTS WITH GONORRHOEA

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10.1136/sextrans-2015-052126.76

Background/introduction Gonorrhoea is a public health problem due to rising incidence and antimicrobial resistance. Health education is a proven health intervention. Planning interventions requires understanding of views of target groups.
Aim(s)/objectives Describe subjective knowledge of gonorrhoea and preferred methods of health education in individuals presenting with gonorrhoea. Identify differences across specified age groups and sexual orientation.
Methods A prospective study recruited 121 individuals with gonorrhoea. Participants completed a questionnaire. Data from questionnaires were anonymised and analysed.
Results Demographic aspects of this study are presented in a separate abstract. Subjective knowledge about gonorrhoea increases with age and is similar in MSM and heterosexuals. Popularity of mobile Apps decreases with age; 43.8% of 18–24 year olds, compared with 25% of over 44 year olds, regard them as beneficial educational tools. 64%, regardless of age or orientation, favour websites as the educational tool for the public. MSM prefer information on posters in social venues (50.7% vs 27.3% in heterosexuals) or by face-to-face interactions with healthcare workers (52.2% vs 23.3% in heterosexuals). Heterosexuals favoured more information in schools compared to MSM (50% vs 33%).
Discussion/conclusion Web-based information was the preferred education method across age groups and sexualities. Posters in bars and clubs would be a good way to target MSM especially as these venues have already been identified as high risk venues associated with GC infection. Future mobile App development should target 18–24 yr olds.

P33 IS TEST OF CURE NECESSARY AFTER DOXYCYCLINE THERAPY FOR RECTAL *CHLAMYDIA TRACHOMATIS* INFECTION?

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Background/introduction We reported a significantly higher treatment failure rate with azithromycin for the treatment of rectal *Chlamydia trachomatis* (CT) when compared to doxycycline (26.2% vs. 0%, p = 0.0025). One-week 100 mg doxycycline twice daily was subsequently recommended as the local first-line treatment for rectal CT.
Aim(s)/objectives To re-evaluate the efficacy of doxycycline therapy in the treatment of rectal CT.
Methods Data was retrospectively collected on all patients diagnosed with rectal CT from 1st October 2010 to 1st October 2013 at a large, inner city sexual health clinic. Information was collected on gender, concurrent sexually transmitted infection (STI), treatment received, adherence to antibiotic, risk of re-infection and 4-week test of cure (TOC). Assessment of risk of re-infection included completion of telephone follow-up, verification of contact tracing of regular partners and absence of unprotected sexual intercourse.
Results 959 patients were diagnosed with rectal CT during the study period. 660 (68.8%) patients received doxycycline therapy in line with local treatment protocol. TOC was performed in 473 (71.7%) patients, of which 22 (4.7%) were positive. Risk of re-infection was excluded in 5 cases (22.7%) and considered possible treatment failures.
Discussion/conclusion The treatment failure rate of doxycycline for rectal CT identified in this study is similar to that reported with azithromycin and is contradictory to our previous findings. The longer study period with larger study population may explain this result. These findings suggest that TOC following treatment of rectal CT is necessary and would not support preferential use of doxycycline over azithromycin.

Category: Clinical case reports

P34 TWO CASES OF ACUTE HEPATITIS E CAUSING A TRANSIENT TRANSAMINITIS IN HIV INFECTED MSM

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10.1136/sextrans-2015-052126.78

Background/introduction Hepatitis E Virus (HEV) is increasing in incidence. Transmission routes include faecal-oral, blood and zoonotically. Patients present with no symptoms; elevated liver enzymes; acute/chronic hepatitis and/or neuropathy. Evidence suggests poorer outcomes among HIV+ patients.
Aim(s)/objectives To describe known cases of HEV/HIV co-infection within a cohort of 2200 HIV+ patients.
Methods We present two cases.
Results Patient-1, a 63-year-old asymptomatic MSM with a 22-year history of HIV, recently re-started Truvada/darunavir/ritonavir: CD4 393(17%) cells/mm^3 and HIV VL 327,824 copies/ml. Routine bloods identified newly elevated ALT 477 IU/L: other liver function, clotting and liver ultrasound were normal. He had no STIs diagnosed in the preceding year nor risk factors for HEV. A hepatitis screen was performed. HEV IgG, IgM and PCR were positive. Treatment was supportive, with normalisation of ALT and negative HEV-PCR after eight weeks. Patient-2, a 41-year-old asymptomatic MSM with an 11-year history of HIV was ART naive: CD4 682(25%) cells/mm^3 and HIV VL 13,109 copies/ml. Routine bloods identified newly elevated ALT 459 IU/L: other liver function, clotting and liver ultrasound were normal. He had no STIs diagnosed in the preceding year

nor risk factors for HEV. Although HEV serology was initially equivocal, IgG and IgM later became positive with detectable PCR. His ALT normalised and HEV-PCR became undetectable four weeks later.

Discussion/conclusion HEV appears to be a self-limiting-asymptomatic illness in HIV+ MSM with good CD4 counts. HEV may be sexually transmitted in populations with increasing STI rates. HEV should be considered a potential cause of elevated liver enzymes in HIV+ patients.

P35 ARE TESTICULAR MIXED GERM CELL TUMOURS ASSOCIATED WITH HEPATITIS C(HCV) IN HIV INFECTED MEN WHO HAVE SEX WITH MEN?

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10.1136/sextrans-2015-052126.79

Background/introduction HCV infection and testicular germ-cell tumours are indicator diseases for HIV-testing in BASHH-guidelines. There is little data on the association of testicular tumours in MSM with HIV.

Aim(s)/objectives We describe 2 MSM with treated HIV-Hepatitis C co-infection who were both subsequently diagnosed with mixed-germ-cell testicular tumours.

Case details Patient-1 is a 51-year-old MSM, diagnosed with HIV in 2004 on Atripla since 2010. In May 2012, routine ALT = 186 and positive HCV-RNA (genotype 1). This was treated with 48-weeks of pegylated-interferon/ribavirin. He had a sustained-viral-response (SVR). Two years later, he presented to the STI-clinic with a four month history of testicular swelling. Ultrasound showed this to be likely malignant infiltration, AFP = 2484, LDH = 426, HCG = 5.9. After orchidectomy, histology demonstrated mixed germ cell tumour. He is in clinical/radiological remission. Patient-2 is a 41-year-old MSM diagnosed with HIV in 2004. In 2007 he received IL-2 in a clinical trial. In both 2008 and 2012 routine ALT = 918,505 respectively and HCV-RNA was positive (genotype 2/3)(genotype 1). HCV was treated with pegylated-interferon/ribavirin both times with SVR. Antiretrovirals (Atripla) were started in 2012. That year, he presented with an E-Coli-UTI and testicular swelling. Ultrasound/orchidectomy found a mixed germ cell testicular tumour. Tumour markers were AFP = 16.5, LDH = 376, HCG = 16.5. He was treated with orchidectomy, bleomycin/etoposide/cisplatin and is in radiological/clinical remission.

Discussion/conclusion HIV infection and hepatitis C treatment are immunosuppressive and are potential causative factors in these HIV-MSM testicular germ-cell tumours. Early investigation of testicular swellings in men with HIV-Hepatitis C is important.

P36 AUTOIMMUNE HEPATITIS IN A PATIENT WITH HIV AND HEPATITIS B CO-INFECTION ALONG WITH LATENT TB: A THERAPEUTIC DILEMMA

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10.1136/sextrans-2015-052126.80

Background/introduction Liver disease is an important cause of morbidity and mortality in patients infected with HIV infection. Abnormal liver function tests are frequently encountered in these patients and often attributed to HAART. Autoimmune Hepatitis is a rare disease with unclear pathogenesis; several viruses have been proposed to act as triggering agents for the inflammatory process of the disease.

Case presentation We present a 46 year old afro Caribbean gentleman who presented with lethargy, weight loss and jaundice. He was diagnosed to be co-infected with HIV and Hepatitis B with a positive autoimmune screen. His persistently elevated liver enzymes warranted a liver biopsy which revealed interface hepatitis, necrosis with lymphocytes and plasma cell infiltrates with variable degree of fibrosis. A picture difficult to interpret in the light of HIV and Hepatitis B infections. His persistently high ALT made it challenging to initiate antiretroviral therapy and the need for steroids to suppress the autoimmune Hepatitis raised a concern regarding the reactivation of the latent TB infection as diagnosed by a positive IGRA test. A review of literature revealed 12 cases of HIV with AIH, but none co-infected with Hepatitis B.

Conclusion There are no clear guidelines for management of autoimmune Hepatitis in HIV and treatment is with immunosuppressive agents. A multidisciplinary approach helped in the management of this gentlemen who now stable on antiretroviral therapy and tapering doses of steroids, along with chemoprophylaxis against latent TB.

P37 SEXUALLY ACQUIRED *SALMONELLA TYPHI* URINARY TRACT INFECTION

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10.1136/sextrans-2015-052126.81

Case report A 22 year old MSM was diagnosed HIV positive with a CD4 cell count was 475 cells/mm3 (35%). He suffered urinary symptoms and *Salmonella typhi* was isolated from urine culture. He recalled a self-limiting afebrile diarrhoeal illness 2 weeks earlier. Stool and blood cultures were negative. He completed a one-week course of ciprofloxacin with subsequently negative cultures. He had no past medical history or significant travel history. He reported unprotected anal intercourse one month before HIV diagnosis, and protected anal intercourse with several partners since diagnosis, but no other infections have been reported locally. All named contacts have declined testing.

Discussion The most common manifestation of *S.typhi* infection is typhoid fever. Most cases in the developed world have been acquired through faeco-oral transmission in endemic areas. Haematogenous dissemination can be widespread and more severe among the immunocompromised. Death ensues in up to 32%. Infection of the genitourinary system is rare. Cases reported have a background of urinary tract abnormalities, invariably with blood and/or stool culture positivity. There are no cases in the literature of sexually acquired *S.typhi* UTI. Infections were acquired through oro-anal contact and pathogen ingestion. None had UTI. Our patient had repeatedly negative blood and stool cultures, reducing the likelihood that this was a disseminated infection leading to UTI, and raising the possibility that the route of infection was though insertive anal intercourse with direct urethral inoculation with *S.typhi*. Unfortunately partner notification has not identified an infected sexual contact to add further weight to this theory.

P38 RESULTS FROM FIRST YEAR OF THE NHS'S FIRST TARGETED 'CHEMSEX' CLINIC IN GUM/HIV

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10.1136/sextrans-2015-052126.82

Background/introduction With much speculation and anecdotal reports regarding the causal links between sexualised recreational drug use by MSM (commonly referred to as 'ChemSex') and HIV/HCV rates, there has been much demand from commissioners and researchers and practitioners to identify the extent of the problem. In 2014, one London GUM/HIV clinic launched the NHS' first targeted ChemSex clinic. This presentation includes robust data collected from 874 unique presentations in the first year of this landmark clinic.
Aim(s)/objectives The objective was to satisfy the health sector's concerns about the extent of this much hyped syndemic, with qualitative and quantitative data as well as assess interventions and cohort engagement methods.
Methods Targeted clinics and outreach services were established with skilled addiction staff and resourcing peer volunteers, collecting culturally and contextually appropriate behavioural trends and data.
Results Data includes:

- Effectiveness of certain contextually-appropriate questions re ChemSex during GUM consultation.
- ARV non-adherence amongst high-risk ChemSex party-goers who favour condomless sex.
- Condom use (or otherwise) and number of partners broken down to include HIV+ve MSM not on treatment.
- HIV/HCV broken down to include sexual acquisition versus injecting drug use acquisition.
- HCV data broken down to include number of re-infections amongst HIV-ve non-injecting drug users.

Discussion/conclusion This presentation includes the data, offers examples of how this model might be adapted in other services, and incorporates some training for attendees in how to overcome fears or ignorance regarding drug use risk assessments and consultations; it also includes film footage of role play exercises for skill-building purposes.

P39 PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY IN A HIV-POSITIVE PREGNANT WOMAN – FIRST CASE REPORTED IN THE UK

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10.1136/sextrans-2015-052126.83

Background/introduction Progressive multifocal leukoencephalopathy, caused by the John Cunningham (JC) polyomavirus, is the third commonest cause of encephalopathy in HIV-infected patient and almost exclusively occurs in immunosuppressed individuals.
Case report A 33-year-old female presented with a late HIV diagnosis during antenatal period and commenced on combivir, darunavir and ritonavir. Baseline viral load was 168,051 copies/ml and CD4 count was 70/100 ml. She then developed right sided weakness and facial droop. Raltegravir was added at 33 weeks gestation. Power on right side was 4/5 with hyperreflexia and a mild cranial nerve VII palsy. Neurological examination done a week prior to presentation found no abnormalities.
Results Routine bloods were unremarkable. CSF analysis showed white cell count of 4×10^6/L predominantly lymphocytes, protein 0.59 g/L, polyomavirus DNA and JC virus DNA positive. Cryptococcal antigen, india ink stain and toxoplasma serology were negative. Initial MRI head showed multiple abnormal areas with the largest abnormal area seen in the left frontal lobe affecting white matter with extension into grey matter. Progress – weakness worsened over the next 2 weeks, power was 1/5 with expressive dysphasia. She was started on 5 days 1 g methylprednisolone which showed no improvement. Due to foetal distress on CTG, emergency caesarean was done at 36 weeks. Viral load at delivery was <40 copies/ml. Darunavir and ritonavir were stopped due to raised ALT, which resolved.
Discussion/conclusion PML progresses rapidly and prognosis is poor. Currently there are no treatment guidelines for PML and studies using mefloquine and methylprednisolone show inconclusive results.

P40 PENILE SQUAMOUS CELL CARCINOMA IN A PATIENT TREATED WITH ETANERCEPT FOR PSORIASIS

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10.1136/sextrans-2015-052126.84

Background Differential diagnosis of genital ulceration includes benign skin disease, infection and malignancy. An increase in sexually transmitted infections in older patients has been seen. Biologics inhibit immune system components that fuel inflammation. They are used to treat refractory chronic inflammatory conditions, including psoriasis. Concerns have been raised regarding an association between use of biologic treatments such as Etanercept and squamous cell carcinoma (SCC). We present a case of a patient taking Etanercept for psoriasis, who developed penile SCC.
Case A 57 years old man, listed by Urology for biopsy of a penile ulcer of 8 week duration, was referred to Genitourinary Medicine to exclude infective causes. He had a long history of severe psoriasis which had been treated with Etanercept for more than 7 years. He had had sex with one casual female partner 3 months prior to presentation. A deep, clean, indurated ulcer was seen on the corona. Regional nodes were impalpable. Tests were negative for syphilis, HIV and herpes simplex. The biopsy showed invasive SCC. He subsequently underwent a partial penectomy.
Discussion Penile cancer is uncommon in the United Kingdom. Embarrassment may cause delay in presentation. Penile SCC has been reported in patients on Etanercept. Clear evidence of association is lacking. Patients on biologics should be advised to carefully examine their skin including the genitals, reporting any skin changes promptly. Increasing awareness among patients and physicians about this possible association could prevent delay in diagnosis. The National Biologic Registers will reveal more definite evidence over time.

P41 STRIBILD™ (EMTRICITABINE/TENOFOVIR/ELVITEGRAVIR/COBICISTAT) AND DARUNAVIR: A NOVEL REGIMEN FOR THE PI EXPERIENCED, RITONAVIR INTOLERANT PATIENT

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10.1136/sextrans-2015-052126.85

Case report We present the case of a 42 yr old female, diagnosed with HIV in 1992, presenting on a failing PI and integrase inhibitor based antiretroviral (ARV) regimen. She was intolerant to ritonavir, had significant drug resistance and poor adherence, but achieved virological suppression using the novel combination of Stribild™ [elvitegravir (EVG)/cobicistat/tenofovir (TDF)/emtricitabine (FTC)] and darunavir (DRV). She had been on multiple ARV combinations since 1994, including NRTI mono-therapy. Medication intolerance, non-adherence and stopping ARVs against advice, had led to HIV drug resistance. Her regimen comprised raltegravir (RAL), DRV, RTV and TDF. Due to her intolerance to RTV, she took this sporadically. This resulted in viral rebound from <40 c/ml to 5,483 c/ml. Cumulative resistance assays demonstrated NRTI, NNRTI and protease inhibitor mutations. Her virus was X4 tropic, but remained sensitive to integrase inhibitors.

To combat this issue a novel approach using Stribild™ with DRV 1200 mg OD was started, taking into account the patient's resistance profile and RTV intolerance. Due to minimal pharmacokinetic (PK) studies of this combination, and the potential for suboptimal and/or altered PK of cobisistat, EVG and DRV, therapeutic drug monitoring was utilised. Adherence was monitored using MEMs CAP™, which showed excellent adherence. Trough drug concentrations at 23 hrs post-dose were 2692 ng/ml for DRV and 1,155 ng/ml for EVG. Subsequently, she achieved rapid virological suppression, asymptomatically.

Discussion/conclusion Issues of drug intolerance and resistance can be a therapeutic dilemma. We present the first case study using the regimen of Stribild™/DRV, utilising cobi to enhance DRV concentrations. This well tolerated salvage regimen may be an option for some individuals.

P42 THE FORENSIC SIGNIFICANCE OF STI'S

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10.1136/sextrans-2015-052126.86

Background/introduction Testing for STI's following sexual assault is routine. In cases were there is no other sexual activity other than the sexual assault, the assailant may be the source, and a positive result of significance in criminal investigation.

Aim(s)/objectives The potential forensic significance of STI results should be considered in each case.

Methods Discussion on information sharing of STI results is undertaken in cases referred to a sexual assault referral centre (SARC) with an absence of other sexual activity. This is documented and includes interpretation of results.

Case 1: An adolescent female, not previous sexually activity, vaginally raped, had a bacterial STI screen and serum save taken hours after the assault. Genital discomfort subsequently developed. A presumptive diagnosis of genital herpes made and tested. Herpes antibody testing was requested on samples taken; initially, when symptomatic and post symptoms.

Case 2: An elderly female, widowed several years earlier and sexually inactive since was vaginally raped. A bacterial STI screen was taken at the time initially and 14 days later.

Results Case 1 – HSV Type 2 confirmed. HSV antibodies initially absent were demonstrated in the post symptomatic sample.
Case 2 – Initial *Chlamydia trachomatis* NAAT tested negative with a positive result at 2 weeks.

Discussion/conclusion The results are supportive of the assailants as the source. The positive Chlamydia result supported the penile vaginal penetration described, allowing consideration of a rape charge rather than a lesser offence. In both cases admissions were made pre-trial avoiding victims being called to court.

P43 DON'T FORGET TO CHECK FOR STIS…. A REPORT ABOUT GONORRHOEA PROCTITIS BEING MISTAKEN FOR A FLARE-UP OF CROHN'S DISEASE

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10.1136/sextrans-2015-052126.87

Background/introduction STIs are not routinely tested for in hospital which means they are often missed when they are an important differential diagnosis.

Aim(s)/objectives To present a case of rectal gonorrhoea (GC) in a patient with well-controlled Crohn's disease (CD) who presented to gastroenterology before diagnosis of GC in GUM.

Methods Case report and literature review.

Case report A 37 year old man presented to gastroenterology with diarrhoea, abdominal pain, proctalgia and tenesmus. He was known to have CD which had been in remission with treatment. X-ray showed faecal impaction and he commenced laxatives. Bowels regularised but remained painful. He was discharged with topical diltiazem, lidocaine gel and Metronidazole. At follow up he reported continuing proctalgia and small amounts of rectal bleeding. Exploration under anaesthesia revealed a peri-anal fissure and a sinus which was de-roofed and treated with local anaesthetic. MRI showed an inflamed anal gland. Colonoscopy, biopsies and stool cultures were normal. He then attended sexual health as he recently found out his regular male partner had been unfaithful. Proctoscopy was painful and revealed discharge and inflamed anal mucosa. On microscopy > 10 neutrophils per high powered field were seen with a mixture of gram positive and negative organisms. Proctitis was treated with Doxycycline. Rectal GC tests were positive and this was treated. At test of cure symptoms had resolved and have not recurred since.

Discussion/conclusion Literature search reveals publications from recent years about STIs being initially misdiagnosed in hospital. This case further highlights the importance of asking routinely about partners in patients with bowel symptoms.

P44 RPR-NEGATIVE PRIMARY SYPHILIS IN MEN WHO HAVE SEX WITH MEN: A CASE SERIES

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10.1136/sextrans-2015-052126.88

Background/introduction Diagnosis of primary syphilis is confirmed by serological tests suggestive of the stage of the disease. In most cases specific (IgM/IgG) and non-specific (RPR)

antibodies develop in response to primary treponemal infection. Lack of development of such antibodies is known to occur amongst HIV positive patients but is unusual among HIV negative patients with no significant comorbidities.

Aim(s)/objectives To present a cluster of four cases of primary syphilis from our clinic with unexpected serological results.

Methods We describe four unusual cases of HIV-negative MSM, all of whom presented with penile lesions (three chancres and an atypical lesion). These cases were identified by clinicians between July 2014 and January 2015. Clinical and laboratory records were retrospectively interrogated. Clinical photographs will be used to illustrate these cases.

Results In all cases, patients with no history of previous syphilis returned positive results on one or more specific treponemal serological tests with persistently negative RPR. Three cases had recent negative syphilis screening at our clinic. Darkfield microscopy also failed to demonstrate T. pallidum in those with chancres. In all cases, treatment of presumed syphilis led to the resolution of the lesions.

Discussion/conclusion These cases demonstrate the ongoing difficulties with treponemal diagnostic test interpretation. There are reports in the literature that men over 35 may be more likely to return a false negative RPR result, but overall prevalence of false negative RPR in primary syphilis is uncertain. Over-reliance on serology may result in under diagnosis of syphilis even in HIV-negative MSM.

P45 RECALCITRANT *TRICHOMONAS VAGINALIS;* A CASE SERIES OF TREATMENT CHALLENGES AT TWO URBAN SITES

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10.1136/sextrans-2015-052126.89

Background/introduction *Trichomonas vaginalis* (TV) remains common in England, with 6475 cases reported in 2013.[1] BASHH guidelines[2] advocate first line TV treatment with metronidazole (2 g stat or 400 mg BD for five to seven days) or a single dose of tinidazole (2 g). Recalcitrant infections have been well documented and may be caused by inadequate therapy, re-infection or antibiotic resistance.[3] In the US, up to 5% of isolates of TV demonstrate a degree of resistance.[4] In the UK there remains no facility to test for TV resistance, leading to multiple 'blind' treatment approaches. We wished to evaluate the prevalence and clinical management of recalcitrant TV in our services.

Methods Clinic databases were used to identify patients with recalcitrant TV attending two sexual health services over a two year period.

Results A total of 1046 cases of TV were seen across the two services in the study period. Four female patients (0.4%) with recalcitrant TV requiring three or more treatments were identified. The patients were aged between aged 25 and 47 years. Two were black British, one white British and one white European. All four patients failed to respond to at least two five day courses of metronidazole; they required between three and eleven different courses of treatment, as per the table below:

During the courses of treatment all four patients were microscopy and culture negative at least once. However, symptoms persisted and tests were subsequently positive on at least one other occasion, despite no risk of reinfection. Three patients subsequently responded to fourteen days of tinidazole and one required acetarsol treatment. Three were eventually cured of TV, taking between 3–7 months to achieve cure and 5 and 12 clinic visits; one was lost to follow up, presumed cured.

Discussion Recalcitrant TV is rare, but for patients affected, the absence of a UK facility to detect TV resistance means that individuals who fail to respond to first line therapy undergo multiple attempts at TV treatment, recurrent clinic visits and investigations.

Abstract P45 Table 1 *Trichomonas vaginalis* case series

	Ethnicity	Age	First line treatment	Subsequent treatments	Time to clinical cure
1	White European	28	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days; TDZ 2 g OD 14 days	4 months (5 clinic visits)
2	Black British	47	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x3 (2 in community); MTZ 400 mg BD 5 day amoxicillin 500 mg TDS + clotrimazole pessary, TDZ 2 g STAT, TDZ 2 g BD 14 days	2 months-Lost to follow-up (5 clinic visits)
3	White British	29	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days × 3; Amoxicillin 500 mg TDS 7 days+clotrimazole pessary + MTZ 400 mg BD 5 days, TDZ 2 g OD for 14 days	3 months (6 clinic visits)
4	Black British	25	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x 3; Amoxicillin 500 mg BD 7 days + MTZ 400 TDS 7 days; MTZ 1 g suppositories 7 days + amoxicillin 500 mg TDS 7 days, MTZ 2 g OD 5 days; TDZ 2 g OD for 14 days; MTZ 400 mg TDS +1 g PR 7 days; TDZ 2 g BD 14 days + TDZ 500 mg BD PV x2 courses; Acetarsol 500 mg pessaries ON 14 days	6 months (12 clinic visits)

P46 THE MANAGEMENT OF ABNORMAL LFTS IN AN HIV POSITIVE PREGNANT WOMAN

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10.1136/sextrans-2015-052126.90

Background Acutely deranged liver function tests (LFTs) in HIV positive pregnant women present challenges in balancing pregnancy-related conditions, antiretroviral (ARVs) toxicities and prevention of mother to child transmission (MTCT). A 34 year old HIV positive lady with a history of poor engagement in care, psychosis, cognitive impairment and recent nevirapine resistance

was admitted at 26 weeks gestation under mental health legislation due to cognitive impairment and self-neglect.
Method She was commenced on darunavir/ritonavir 600 mg bd, truvada and raltegravir but three weeks later, at 29 weeks gestation, she developed rapidly progressive hepatic transaminitis. Abdominal ultrasound scan was normal and tests for viral hepatitis negative. Pre-eclampsia was excluded, leaving three working diagnoses: drug-induced hepatitis, obstetric cholestasis or acute fatty liver of pregnancy. ARVs were stopped but transaminases continued to rise (ALT 614 and AST 716 U/L). Clotting screen and platelet count remained normal but the patient began to complain of epigastric pain. HIV viral load had risen to 241 copies/ml. In view of deteriorating maternal health and the increasing risk of MTCT (HIV viral load expected to rise), the baby was delivered at 31 weeks' gestation by semi-elective caesarean after a course of antenatal steroids. The baby received antiviral prophylaxis in the form of abacavir, lamivudine and zidovudine; HIV RNA was undetectable at three months (MTCT extremely unlikely). Nine days after delivery the patient's LFTs normalised.
Conclusion Darunavir-induced hepatitis typically presents with increased AST and ALT. In this case, LFTs only started to improve following delivery of the baby, suggesting a pregnancy related cause.

P47 HIV SEROCONVERSION IN PREGNANCY RUNS AN INCREASED RISK OF MOTHER TO CHILD TRANSMISSION (MTCT)

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10.1136/sextrans-2015-052126.91

Background We present the case of a couple who attended our sexual health service – him with a Severe Primary Herpes episode and other indicators of immune compromise and her in her 41st week of pregnancy. Their last sexual contact was nine days previously. Urgent HIV testing was undertaken using a fourth generation test with the male partners' test being positive and the female partners' test being negative. Viral load testing was requested with a result anticipated in 24 h.
Method During the night his partner went into labour. We calculated the risk of MTCT in this unique situation as being approximately 1:4000 and advised the patient that this could be decreased to 1:10 000 with Nevirapine, Zidovudine and a delivery by caesarean section. The baby received triple drug antiviral therapy until a negative viral load was confirmed approximately 6 h after delivery. Due to the risk of seroconversion the mother decided not to breastfeed even with antiretroviral cover, although sterilisation of expressed breast milk was discussed. Management of serodiscordant couples during pregnancy with ongoing risk of transmission is not discussed in the BHIVA guidelines and there is little evidence/guidance to base decisions around breastfeeding and retesting on.
Conclusion We wonder if we had been able to get a viral load on the female sample more quickly, would it have prevented caesarean section or would concerns around risk of acquisition from the genital tract during vaginal delivery (should she be in the 'eclipse' phase of HIV) have still made us advise an operative delivery.

P48 MYCOBACTERIAL SPINDLE CELL PSEUDOTUMOUR IN A PATIENT WITH HIV

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10.1136/sextrans-2015-052126.92

Background/introduction Mycobacterial spindle cell pseudotumour is a rare, benign lesion caused by local proliferation of histiocytes in response to mycobacterial infection. It most commonly occurs with mycobacterium avium intracellulare. Most cases affect lymph nodes, skin and brain. We present a case occurring in the lung of a patient with HIV.
Methods A 38 year old Caucasian gentleman was admitted with 1 year history of weight loss, cough and diarrhoea. As a result of declining health and recent HIV diagnosis, he had returned to UK after living 8 years in Thailand. He had commenced anti-TB drugs 6 weeks previously; however no details were available regarding previous investigations. He was profoundly immunosuppressed, with CD4 count < 10 copies/mm^3. CT chest showed widespread cavitating lesions throughout both lung fields. Cultures from sputum and bronchial washings grew mycobacterium avium intracellulare and clarithromycin was added. Antiretroviral treatment was started 2 weeks later. Biopsies from bone marrow and bowel showed no evidence of granuloma or malignancy. He suffered frequent episodes of hypercalcaemia. As a result of this, and lack of radiological response to mycobacterial treatment and ARV, CT guided lung biopsy was carried out. This showed mycobacterial spindle cell pseudotumour. Clinically he continued to improve, with immune recovery. Anti-mycobacterial treatment was to continue for 12 months.
Discussion/conclusion Mycobacterial spindle cell pseudotumour is a rare complication of mycobacterial infection. The majority of patients are immunocompromised, including those with advanced HIV. It may share some histological features with Kaposi Sarcoma, therefore correct identification is essential. Treatment depends on the mycobacterial species identified.

P49 TOXIC CARDIOMYOPATHY IN A STABLE HIV PATIENT WITH A HISTORY OF AMPHETAMINE MISUSE-A CASE REPORT

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10.1136/sextrans-2015-052126.93

Background/introduction Amphetamine (AM) use is associated with HIV infection among MSM. There are various toxic effects of AM, cardiotoxicity being one of them.
Aim(s)/objectives To present a case of report of cardiomyopathy secondary to AM misuse in a patient with well-controlled HIV.
Case report A 51 year old HIV positive MSM was admitted to hospital with dyspnoea, orthopnoea and decreased exercise tolerance. He was HIV positive since 1990 and this is stable on ARVs. CD4 count pre-admission was 514 with undetectable viral load. He used 25–30 grams of AM per week over a period of 20 years and had multiple casual unprotected MSM partners. On admission, the patient was tachycardic and hypoxic. Chest X-Ray on admission showed cardiomegaly and bi-basal opacification. Echocardiogram demonstrated severe left and right

ventricular dysfunction, at a level requiring cardiac transplant. ECG showed prolonged QT interval. The patient was diagnosed with toxic dilated cardiomyopathy secondary to long term AM abuse. UK guidelines for Heart transplantation in adults deem chronic viral infection and ongoing substance misuse as relative contraindications to transplant. He was consequently commenced on medication for cardiac failure and received benzodiazepine as inpatient for managing withdrawal symptoms. On discharge, psychiatry follow-up was organised for support to help reduction of AM. At follow up, the patient reported reduced AM use by quarter, but felt he could never abstain.
Discussion/conclusion AM related cardiac fatalities are caused by acute myocardial necrosis, ventricular rupture, cardiomyopathy or arrhythmia. Evidence is mostly derived from case-reports. Patients using AM should be fully counselled regarding possible toxic effects.

P50 NON-ISCHAEMIC DILATED CARDIOMYOPATHY IN HIV POSITIVE PATIENTS; A CASE SERIES

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10.1136/sextrans-2015-052126.94

Background HIV is a well-known cause of dilated cardiomyopathy, with an annual incidence of 15.9 per 1000 asymptomatic HIV patients in the pre-HAART era. Despite reduced incidence with HAART, it remains an important cause of cardiac morbidity in people with HIV though its direct association to the virus is unclear.
Methods Retrospective case review.
Results Four patients with dilated cardiomyopathy were identified out of 4739 attending between 2002–2014. Mean age was 49 years (range 38–62), all were male. Two presented as admissions with cardiac failure; two were diagnosed on routine investigation for exertional dyspnoea. All clinically improved with medical management; the three cases under long term follow up (6–10 years) showed improvement in ejection fraction (EF), though one died 10 years post diagnosis of presumed sudden-cardiac death.
Discussion This small case series highlights the positive outcomes with medical management of dilated cardiomyopathy in HIV. The direct role of HIV remains unclear; these cases reinforce the importance of regular screening for recreational drug use and consideration of their potential cardiotoxicity, and awareness of other aetiological factors.

Category: Electronic patient records and use of information technology

P51 THE UTILITY OF PERSONALISED SHORT MESSAGE SERVICE (SMS) TEXTS TO REMIND PATIENTS AT HIGHER RISK OF STIS AND HIV TO RE-ATTEND FOR TESTING

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10.1136/sextrans-2015-052126.95

Background Patients at increased risk of STI/HIV acquisition are advised to re-attend for re-testing. A previous study showed that 'generic' text reminders did not improve re-attendance.
Aim To assess if a personalised text message would increase re-attendance rates of at risk patients who require repeat STI testing.
Methods At-risk patients were sent a text reminder to re-attend for re-testing 6 weeks after their initial visit. They were considered to be 'at risk' if they had an acute STI or had attended for emergency contraception at the initial visit, or were MSM. Re-attendance rates were measured for September to December 2012 (control group who received a generic text message advising re-attendance) and February to May 2014 (personalised message group who received a text message containing their first name and several different ways to contact the clinic). Re-attendance was counted within four months of the end of the initial episode of care.
Results The re-attendance rate was significantly higher for the personalised message group (144/266(54%) than the control group: (90/273 (33%) ($P = 0.0001$) and was also significantly higher in the personalised message group than the control group in patients with the following risks: recent chlamydia (61/123 (50%) vs (43/121(36%) ($P = 0.03$), recent gonorrhoea (42/64 (66%) vs (4/21(19%) ($P = 0.0003$) and MSM (25/45(56%) vs (3/18(16%) ($P = 0.006$). New STI rates in the re-attending 'personalised message' group and controls were 26/144(18%) and 13/90 (14%) (n.s) respectively.
Conclusion Sending a personalised text message as a reminder for re-testing increases re-attendance rates in patients who are at higher risk of STIs.

P52 KEEPING "APP" TO DATE: USING GEOLOCATION APPS TO SIGNPOST TO LOCAL SEXUAL HEALTH SERVICES

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10.1136/sextrans-2015-052126.96

Background/introduction To encourage HIV testing amongst men who have sex with men (MSM) during "National HIV testing week" (NHTW) point of care testing (POCT) was offered at community and hospital-based sexual health services (SHS). Users of the social networking application "Grindr" within 5 miles of our clinics received a link to our website, which was upgraded to include a video demonstrating HIV POCT. Traditional health promotion poster campaign was also employed.
Aim(s)/objectives To review advertising strategies used and clients who requested POCT during NHTW.
Methods Activity data was obtained from the software company and electronic records of those attending for POCT were reviewed.
Results 43 asymptomatic attendees requested POCT testing, 35 male and 8 female. 21 males identified as MSM (60%), 15 (71%) disclosed that they had attended as a result of the "Grindr" advertisement. The average MSM number of daily visits to the website increased from 250 to 600/ day, highest at weekends the majority via "Grindr". POCT video was viewed 126 times during testing week. 30 (70%) patients accepted a sexual health screen, 3 asymptomatic infections were diagnosed. No HIV diagnoses were made.
Discussion/conclusion Social networking proved popular amongst MSM. No HIV diagnoses were made however screening increased HIV testing and identified sexual infections in

asymptomatic individuals (all signposted via "Grindr"). Current work includes using "Grindr" to signpost users to our service, implementing online booking and expanding the use of POCT at community SHS. Clinics should consider using social media and geolocation-based apps in addition to traditional health promotion.

P53 WITHDRAWN

P54 SYSTEMATIC REVIEW AND META-ANALYSIS OF RANDOMISED CONTROL TRIALS OF INTERACTIVE DIGITAL INTERVENTIONS FOR SEXUAL HEALTH PROMOTION

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10.1136/sextrans-2015-052126.97

Background Digital technology offers potential for sexual health promotion.
Aims We conducted systematic review examining effectiveness of sexual health promotion interactive digital interventions (IDI) compared to 1) minimal interventions (e.g. leaflet); 2) face-to-face interventions; 3) different IDI designs.
Methods IDI require users' contributions to produce personally relevant feedback. We searched 40 electronic databases for randomised controlled trials (RCT) of IDI for sexual health promotion from start dates to 30/04/2013. Separate meta-analyses were conducted for comparisons 1, 2, and 3, by outcome types (knowledge, self-efficacy, intention, sexual behaviour, biological outcomes) using random effects models. Subgroup analyses tested: age, risk grouping, setting (online, healthcare, educational).
Results We identified 36 RCTs (11,818 participants) from developed countries. Comparison 1: IDI improved knowledge ((standardised mean difference (SMD) 0.48, 95% CI 0.19 to 0.76)); self-efficacy (SMD 0.11, 95% CI 0.04 to 0.19), intention (SMD 0.13, 95% CI 0.05 to 0.22), sexual behaviour ((Odds Ratio (OR) 1.20, 95% CI 1.02 to 1.41)), but not biological outcomes (OR 0.81, 95% CI 0.56 to 1.16). IDI delivered in educational settings improved sexual behaviour (OR 2.09, 95% CI 1.43 to 3.04), but not in healthcare settings (OR 1.17, 95% CI 0.94 to 1.45), or online (OR 0.96, 95% CI 0.79 to 1.17). Comparison 2: IDI improved knowledge (SMD 0.36, 95% CI 0.13 to 0.58), intention (SMD 0.46, 95% CI 0.06 to 0.85), but not self-efficacy (SMD 0.38, 95% CI -0.01 to 0.77). Comparison 3: Tailoring had no effect on outcomes.
Conclusion IDIs can enhance knowledge, self-efficacy, intention, and sexual behaviour.

P55 THE USE OF WEB-BASED TECHNOLOGY TO MEASURE PATIENT EXPERIENCE IN SEXUAL HEALTH SERVICES

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10.1136/sextrans-2015-052126.98

Introduction In comparison to other specialities, generating feedback from sexual health patients on clinic experience is challenging. Web-based technology can address many challenges associated with paper-based surveys, and is increasingly used to generate feedback in healthcare. A survey conducted in our service showed that four-fifths of our patients use smartphones; we therefore wanted to use technology to capture patient experience of our service.
Aim To measure real-time patient experience of our sexual health service using an online questionnaire.
Methods Since May 2014, new patients attending one of our five services are sent a link to an online survey via free text message. The short survey captures demographic data and feedback, with facility to request call back to discuss any concerns.
Results Since May 2014, 2457 new patients (18%) have completed the survey (2457/13753).
Discussion We have demonstrated high levels of satisfaction with our service as a result of this online survey. Implementation challenges include varying response rates, administration time and cessation of free messaging. However, the generation of real-time feedback is valued by staff, commissioners and patients, and has resulted in several service improvements e.g. improved signage and new processes for triaging patients.

P56 ELECTRONIC PATIENT RECORDS (EPR) AND THE IMPACT ON ATTENDANCE WITHIN A LEVEL 3 SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.99

Background Staff complained that the introduction of the EPR in December 2013 slowed down their consultations and thought that attendances had reduced significantly as a result of having to "cap" walk in clinics and reduce the number of appointment slots. In the early months post implementation there were

Abstract P55 Table 1 Patient survey results

Clinic	Percentage responses	Male	Seen within 30 mins	Treated with dignity/respect (strongly agree/agree)	Would recommend service (strongly agree/agree)
C1	(1090/7417) 15%	48%	49%	97%	94%
C2	(493/2200) 22%	35%	24%	93%	90%
C3	(255/1605) 16%	52%	46%	95%	92%
C4	(276/1921) 14%	38%	22%	96%	88%
C5	(343/610) 56%	15%	50%	90%	81%

increasing reports of clinics overrunning and patients not waiting to be seen. Verbal complaints from patients rose as they felt the impact on the service. Over time as the EPR became established these concerns and complaints lessened.
Aim To identify whether or not the EPR has significantly impacted on the footfall of patients attending a level three sexual health service.
Methods Comparison data was extracted from IT system and inserted in to data sheets from a service analysis in 2010.
Results

Abstract P56 Table 1 Patient footfall

Year	New	Follow up	DNA
2010	10375	2628	1222
2014	10234	2156	835

Discussion The observed difference both for New and FU patients in 2010 and 2014 is small despite staff feeling there has been a negative effect on patient attendance. There has been active encouragement to decrease the number of FU patients to improve DNA rates, which has reduced by 32% (2010–2014). Overall in the year 2014 there is little evidence that the IT system has significantly impacted on the footfall of patients attending a level 3 service, despite clinics being minimised and appointments decreased to manage attendance levels.

Category: Epidemiology and partner notification

P57 TO DISCLOSE OR NOT TO DISCLOSE. AN EXPLORATION OF THE MULTI-DISCIPLINARY TEAM'S ROLE IN ADVISING PATIENTS ABOUT DISCLOSURE WHEN DIAGNOSED WITH GENITAL HERPES SIMPLEX VIRUS (HSV)

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10.1136/sextrans-2015-052126.100

Background HSV is the leading cause of genital ulcerative disease worldwide. Medical experts condemned the first UK prosecution for genital herpes transmission in 2011. There is a lack of research investigating what patients are being advised by the multidisciplinary team regarding disclosure.
Aim To explore the nature of advice given to patients by the multidisciplinary team regarding HSV disclosure to partners.
Methods A qualitative descriptive study. Ten semi-structured interviews were conducted. Participants: two sexual health advisors, three nurses, three consultants and two specialty doctors. The interviews were transcribed verbatim and analysed using Burnard's Thematic Content Analysis.
Results Four key themes emerged: (1) '*HSV – The Facts*', explored the medical aspects of the infection; (2) '*Stigma and Psychological Aspects of HSV*', explored participant's experiences of the emotional aspects of HSV; (3) '*The Challenge of Disclosure*', explored participant's views and experiences of discussing disclosure; (4) '*The Legal Case – Revenge not Justice*', explored participant's views on the legal prosecution.
Discussion/conclusion Participants believed disclosure to be the patient's choice. There was a general consensus that disclosure was not required due to the prevalence of HSV. Notably, participants had not altered their practice to advise disclosure to all partners in accordance with local protocol. An aspect found within the findings but not in the previous literature was the normalisation of HSV. Participants used the prevalence of HSV in an attempt to normalise and de-stigmitise the infection. This study disputed a key finding from the literature review that healthcare providers were providing inaccurate information about HSV.

P58 A REVIEW OF HEPATITIS C TESTING IN A DISTRICT GENERAL HOSPITAL – A CASE FOR TESTING COCAINE USERS AND SEXUAL CONTACTS OF HIV NEGATIVE HEPATITIS C PATIENTS?

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10.1136/sextrans-2015-052126.101

Background/introduction Hepatitis C has significant public health consequences and substantial morbidity and mortality. Timely identification and treatment is needed to avert the rising prevalence of Hepatitis C related chronic liver disease. There is currently an inconsistency in the guidance for which groups to screen, with BASHH and Public Health UK recommending slightly differing protocols.
Aim(s)/objectives The aim of this project was to audit Hepatitis C testing in the Rotherham GU medicine clinic against the standards set out by the Public Health England Migrant Health Policy.
Methods All hepatitis C antibody positive diagnoses between January 2010 and May 2014 were identified. A retrospective case note review was undertaken to ascertain the indication for hepatitis C testing.
Results 25/27 of the hepatitis C positive patients were tested for a reason recommended by the Public Health England guidelines:

Abstract P58 Table 1 Hepatitis C testing

Rationale for testing	Percentage	Percentage of testing in line with Public Health UK Guidance
Intravenous drug use	88.9%	92.6%
Born outside of Western Europe	3.7%	
Intranasal cocaine use	3.7%	
Sexual contact of Hepatitis C	3.7%	

Discussion/conclusion Two of the patients were tested for reasons other than those listed by Public Health England and BASHH guidance. The issue of hepatitis C testing in cocaine users and HIV negative heterosexual contacts is currently under scrutiny by Public Health England and NICE, however neither advocates testing based upon these. Our audit data suggests that hepatitis C testing may be advisable in intranasal cocaine users

and sexual contacts of hepatitis C. There are epidemiological studies to support these findings.

P59 A SYSTEMATIC REVIEW OF ASSOCIATIONS BETWEEN SUBSTANCE USE AND SEXUAL RISK BEHAVIOUR, STIS AND UNPLANNED PREGNANCY IN WOMEN

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10.1136/sextrans-2015-052126.102

Background/introduction Associations between substance use and sexual risk among general populations of women may be helpful in the development of a sexual risk assessment tool for community health settings.
Aim(s)/objectives To review the evidence for whether smoking, alcohol and drug use variables are associated with reporting of unprotected sexual intercourse, multiple partnerships, STI diagnoses and unplanned pregnancy in women aged 16–44 years.
Methods Seven electronic databases were searched for probability population surveys published between 31/1/1994 and 31/1/2014 that reported on at least one of the outcomes above. Studies were included on women aged 16–44 years in the European Union, Australia, New Zealand, USA or Canada. An independent reviewer screened 10% of title and abstract exclusions and all full-text papers.
Results Three papers were identified. Current smoking was associated with unplanned pregnancy in the last year (Wellings 2013) and with current non-use of contraception among women (Xaverius 2009). Reporting ever smoking daily was also associated with reporting larger numbers of lifetime sexual partners (Cavazos-Rehg, 2011). Drug use in the last year (excepting cannabis) was associated with unplanned pregnancy (Wellings 2013). Cavazos-Rehg, 2011 found a dose response between lifetime partner numbers and heaviness of marijuana and alcohol use. Conversely Xaverius, 2009 found alcohol use was lower among those reporting current non-use of contraception.
Discussion/conclusion No clear direction emerged for the association with alcohol use, in contrast to drug use and smoking. Further research is needed to establish if alcohol has utility in a women's sexual risk assessment tool for community use.

P60 ASSOCIATIONS BETWEEN SUBSTANCE USE AND SEXUAL RISK BEHAVIOUR AMONG WOMEN AGED 16–44 YEARS: EVIDENCE FROM BRITAIN'S THIRD NATIONAL SURVEY OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL-3)

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10.1136/sextrans-2015-052126.103

Background/introduction Taking account of substance use may be important when developing a sexual risk assessment tool for use with women in community health settings.
Aim(s)/objectives To examine whether different measures of substance use have different associations with key sexual risk behaviours among women in the British general population (rather than women attending sexual health clinics who typically report higher risk behaviour).
Methods We analysed data from 4,911 female participants aged 16–44 in Natsal-3, a national probability sample survey undertaken 2010–2012, using multivariable regression to examine the associations between substance use variables and reporting: multiple (2+) partners in the last year; non-use of condoms with multiple partners in the last year; non-use of condoms at first sex with most recent partner.
Results Reporting multiple partners was associated with current smoking (OR 1.59, 95% CI 1.30–1.93), weekly binge drinking (OR 2.47, 95% CI 1.97–3.10), and drug use ever (OR 1.45, 95% CI 1.20–1.75). Similarly, reporting non-use of condoms with multiple partners was also associated with current smoking (OR 1.39, 95% CI 1.09–1.78), weekly binge drinking (OR 2.47, 95% CI 1.90–3.21) and drug use ever (OR 1.48, 95% CI 1.17–1.88). Non-use of condoms at first sex with most recent partner was only associated with current smoking (OR 1.47 95% CI 1.25–1.73) and weekly binge drinking (OR 1.41 95% CI 1.14–1.73).
Discussion/conclusion Differences were found to exist in how substance use variables are associated with the sexual risk behaviours studied. Different substance use questions may therefore be useful in identifying and distinguishing different sexual risk behaviours profiles in community settings.

P61 PSYCHOSOCIAL DETERMINANTS OF HIV DISCLOSURE TO CONFIDANTS WITH DIFFERENT HIV STATUS

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10.1136/sextrans-2015-052126.104

Background/introduction Informing HIV-negative people by people living with HIV (PLWH) about their status might probably have great HIV preventive effect. That is why it's important to study the factors of HIV disclosure to confidents with different HIV status.
Aim(s)/objectives The goal of the study was to reveal the psychosocial determinants of HIV disclosure to confidents with different HIV status.
Methods In 2013 we surveyed 418 PLWH in Saint Petersburg, Russia. We employed Internalised AIDS-Related Stigma Scale (IA-RSS), SF-36 Health Status Survey, Multidimensional Scale of Perceived Social Support (MPSS), the Lubben Social Network Scale (LSNS). The interview guide also contained the question about HIV status of those people, who were informed about respondents' HIV status by respondents themselves.
Results The sample was 58% of male (mean age = 34.3 years). An average time of identification of HIV was 6.3 years before the study. Logistic regression model explaining HIV disclosure to people with positive or/and negative HIV status included the

average time passed since identification of HIV (OR = 0.989; p 0.01); self-stigma (IA-RSS) score (OR = 1.336; p 0.01); general health (SF-36) score (OR = 0.977; p 0.05), perceived social support provided by friends (MPSS) (OR = 1.323; p 0.05), family (OR = 1.217; p 0.01) and friendship network sizes (LSNS) (OR = 0.825; p 0.01).

Discussion/conclusion Our data suggest that HIV disclosure to confidents with different HIV status is determined by the objective and subjective characteristics of interaction with the other people, as well as the quality of life and maybe disease progress.

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P62 SHARING WEBSITE PAGES TO SUPPORT DISEASE AND PARTNER NOTIFICATION

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10.1136/sextrans-2015-052126.105

Background/introduction Disease and partner notification (PN) are two key roles for a sexual health service; however, there is no simple way to deliver these services. The challenge is amplified when patients and partners are not local to the clinic.

Aim(s)/objectives We therefore tested if enabling a sign posting and information website to share pages by email or text would have utility.

Methods The database of shared pages from 01/08/2013 to 31/01/2015 was reviewed and the most popular identified. The IP address was used to determine the number of unique computers/mobile devices used for this purpose.

Results 109 unique devices shared a total of 662 pages over 542 days of analysis. The biggest users were the result teams of two sexual and reproductive health clinics.

Discussion/conclusion Sharing pages has been used successfully to communicate with patients about infections, clinic locations and contraception. The decision by NHS mail to stop their text services in April 2015 creates a real need to develop this functionality further to effectively communicate with patients.

Abstract P62 Table 1

Number of shares	Page description
146	Clinic A page for addess and transport
85	Chlamydia
35	Gonorrhoea
40	Sexually Transmitted Infections
23	Home page
20	Implant
16	Clinic B page for addess and transport
15	Combined contraceptive pill
15	Intrauterine system
15	Herpes
14	Clinic C page for addess and transport
8	Syphilis
8	Trichomonas vaginalis
5	Progestogen only pill
5	Non-specific urethritis

P63 FIFTEEN YEAR TRENDS IN HIV DIAGNOSES AMONG MEN WHO HAVE SEX WITH MEN IN THE UNITED KINGDOM: 1999–2013

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10.1136/sextrans-2015-052126.106

Background/introduction As in many other western countries, men who have sex with men (MSM) are most affected by HIV in the UK.

Aim(s)/objectives To describe 15-year trends in HIV among MSM to inform prevention strategies.

Methods National HIV surveillance data were linked to national register deaths and HIV testing data from sexually transmitted infection (STI) clinics. Multivariable analyses revealed predictors of late diagnosis (<350 copies/mL) and mortality.

Results Between 1999–2013, 37,560 MSM (aged 15) were diagnosed with HIV; diagnoses increased from 1,440 (1999) to 3,250 (2013). The majority of men were white (85%) and UK-born (68%). Probable UK-acquisition was high (81%) including among those born abroad (66%). Median CD4 count rose, 350 cells/mm^3 to 463 cells/mm^3. Despite a decline in late diagnosis (50% to 31%), >800 men have been diagnosed late annually since 2004. HIV testing in STI clinics in England increased, 10,900 to 102,600. One-year death rates among new diagnoses declined (4.6% to 0.9%) due to fewer deaths among late presenters (4.4% to 1.8%). Older age (>50) and living outside London were predictors of late presentation, while older age and late presentation were predictors of one-year mortality.

Discussion/conclusion In its third decade, the HIV epidemic among UK MSM has continued to diversify. Increases in new diagnoses reflect both increased testing and ongoing transmission. Despite improvements in patient outcomes, >800 men present late each year; death rates remain high and preventable. Culturally appropriate prevention and testing strategies require strengthening to reduce HIV transmission and late diagnosis.

P64 EXPERIENCES OF MEN WHO HAVE SEX WITH MEN (MSM) WHEN ENGAGING IN THE PARTNER NOTIFICATION PROCESS THREE MONTHS FOLLOWING A HIV DIAGNOSIS

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10.1136/sextrans-2015-052126.107

Background/introduction Partner Notification (PN) can be used as a tool for detecting undiagnosed HIV, but fear of stigma around disclosure and concerns about lack of confidentiality are potential barriers and may deter newly diagnosed individuals from engaging in this activity.

Aim(s)/objectives To identify facilitating or prohibiting factors for HIV infected MSM when undertaking partner notification following HIV diagnosis.
Methods Semi structured interviews with ten newly diagnosed HIV MSM. All were recruited from a local NHS HIV outpatient service. Interviews were recorded verbatim and framework analysis was used to analyse the data.
Results Facilitating factors: There was a general acceptance and an awareness of necessity to initiate PN with immediacy, given the potential risk of onward transmission. Most participants expressed a "social responsibility "to inform partners of their HIV status if contactable, with a preference for disclosure through face to face contact if regular partner/s, but acknowledged that provider referral would be a useful option for non-regular or casual partners. Through "self-assessment of risk" most were able to identify the potential source of acquisition, and partners that could be "at risk" or infected. Prohibiting factors: Concerns about stigmatisation and criminalisation around disclosure of status remain key concerns, but participants particularly valued the support received from HCPs around addressing all aspects of PN.
Discussion/conclusion Important themes were identified that should be considered when supporting individuals in disclosing their HIV status to partners, providing a deeper understanding of the PN process from a patient's perspective and generating ideas that should be considered in future service provision and HIV PN studies.

P65 SEXUAL BEHAVIOUR IN THE TIME PERIOD BETWEEN BEING TESTED FOR CHLAMYDIA AND RECEIVING TEST RESULT AND TREATMENT

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10.1136/sextrans-2015-052126.108

Background/introduction There is a lack of data on the sexual behaviour of patients between being tested for chlamydia, receiving the test result, and being treated. This time-period may be important in the transmission of chlamydia, as infection could continue to be spread to sexual partners whilst awaiting the test result and treatment.
Aim(s)/objectives To investigate the sexual behaviours of patients between the time of being tested for chlamydia and receiving test result and treatment in order to investigate the benefits that a point-of-care test (POCT) might bring to clinical practice.
Methods We conducted a cross-sectional clinical audit of GUM clinic attendees. Clinic staff conducted a notes review of patients returning for chlamydia treatment following a positive chlamydia test result, and of age- and sex-matched chlamydia negatives. The data also served as an audit for the GUM clinics, following BASHH guidelines.
Results Five of nine GUM clinics approached participated, in July–December 2014. Data from 775 patients were included in analyses, 365 of whom were chlamydia-positive. Males with 2–4 partners, and those who reported never using a condom, were more likely to be chlamydia positive. For 21/143 (14.7%) positive patients who provided data, last new sexual contact was in the period between test and treatment. Data were missing on condom use (22%) and recent new partners (81%).
Discussion/conclusion Patients continue to form new sexual partnerships whilst awaiting chlamydia test results, allowing for the possibility of infecting new sexual partners. POCTs which remove the test to treatment delay could prevent this onward transmission.

Category: HIV prevention, PEPSE and PREP

P66 BASHH REGIONAL AUDIT OF PEPSE PROVISION IN THE NORTH-WEST OF ENGLAND

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10.1136/sextrans-2015-052126.109

Introduction Post-exposure prophylaxis following sexual exposure (PEPSE) to HIV is an established method of reducing HIV transmission.
Aims Review of the provision of PEPSE in North-West England against BASHH national auditable standards.
Methods Retrospective case note review of patients attending 15 genitourinary medicine clinics in the North-West England for PEPSE between 1st January 2013 and 31st December 2013. A maximum of 30 cases per centre were reviewed.
Results Of 203 cases reviewed 140 (67.0%) were male, of whom 118 were MSM. Mean age was 31.5 years (range 15–75 years); 168 (82.8%) were White British. HIV testing within 5 days of PEPSE initiation was recorded for 185 (91.1%). Genitourinary departments starting PEPSE provided HIV testing for 103/112 (92.0%) at baseline. Other departments starting PEPSE tested 10/91 (11.0%). PEPSE was initiated for recommended indications in 187 cases (92.1%) and 185 (91.1%) were started within 72 h of exposure. Twenty-eight days of PEPSE was completed by 123 (60.6%); 21 (10.3%) discontinued early; 59 (29.1%) did not have their treatment duration documented. STI screening was documented and accepted by 163 (80.3%). A total of 98 (48.3%) were HIV tested at 12 weeks post-PEPSE; all were negative. For those documented as completing PEPSE 76/123 (61.8%) were HIV tested at 12 weeks post-PEPSE. At 6 months post-PEPSE 3 patients tested HIV-positive.
Conclusion PEPSE provision in the North-West met recommended standards for treatment initiation. However standards for PEPSE completion follow up and STI testing were not met. Documentation during follow up significantly impaired results and needs improvement.

P67 PEP AWARENESS AMONGST A HIV-POSITIVE COHORT: WHO KNEW?

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10.1136/sextrans-2015-052126.110

Introduction BASHH guidance recommends proactively educating HIV-infected patients regarding the availability of post-exposure prophylaxis (PEP). Existing evidence suggests PEP awareness is low amongst HIV-infected cohorts, particularly amongst heterosexuals, older patients and those with long-standing HIV diagnoses. We reviewed our educational provision by assessing current awareness in our cohort.
Aims To establish current PEP knowledge, and patient factors influencing that knowledge.
Methods All HIV outpatients were prospectively assessed via questionnaire between 3/7/14–3/1/15. Following data collation PEP aware and PEP unaware patients were compared using chi-squared and Mann-Whitney testing with significance defined as $p < 0.05$.
Results 155 patients responded, 148 were Caucasian; 118 identified as men who have sex with men. 117 (75.5%) were PEP aware of which 108 knew how to access PEP if required. 109 (70.3%) had an undetectable HIV viral load (<20 copies/mL). Attaining an undetectable viral load did not significantly affect awareness (83/117 v 26/38, $p = 0.768$). Patients who were currently sexually active were not significantly more aware (77/117 v 19/38, $p = 0.082$) but those reporting contact with HIV-negative partners were (50/117 v 7/38, $p = 0.007$). Median time since diagnosis was significantly less in those aware of PEP (7.88 years v 11.33 years, $p = 0.006$). Age, gender and ethnicity did not significantly affect awareness.
Conclusion PEP awareness was prevalent and distributed evenly across all demographics. Awareness was significantly higher in those reporting HIV-negative partners, a group in which PEP awareness is especially important. Patients with long-standing diagnoses were shown to have poorer awareness and should be a target group for PEP education.

P68 SEXUAL HEALTH LITERACY AND MEN WHO HAVE SEX WITH MEN (MSM): A SCOPING REVIEW OF RESEARCH LITERATURE

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10.1136/sextrans-2015-052126.111

Background Health literacy is a priority for health policy. However, there is limited research on how health literacy influences sexual health, particularly among men who have sex with men (MSM).
Aim To review sexual health literacy research among MSM in high-resource countries (UK, Canada, USA, Australia).
Methods We searched relevant databases (MEDLINE, Embase, Health and Psychosocial Instruments, Web of Science) to identify research which examined sexual health literacy and MSM *explicitly* and *implicitly* (using formal and informal articulations of health literacy) along with a set of sexual health and MSM terms. Relevant articles were identified, coded and assessed to illustrate the range of evidence available.
Results We found no studies *explicitly* focusing on sexual health literacy, and three exploring health literacy. Findings highlight the need for tailored information, healthcare and promotion for different groups of MSM, variable health literacy levels, and the importance of social context. We found 611 articles that *implicitly* explored sexual health literacy. We analysed a sub-sample which focused on interactive health literacy (negotiating, applying knowledge and interaction). There was a strong focus on communication and negotiation (verbal, non-verbal and online) with sexual partners and health providers, and the varying contexts within which these interactions take place.
Discussion We found no research on *explicit* sexual health literacy with MSM. Clinic-based interventions could use health literacy as a tool to improve sexual health. Findings suggest that tailored health information, communication skills, and the role of social context in shaping sexual health literacy skills could play a critical role.

P69 IMPROVING MANAGEMENT OF MSM PATIENTS WITH REPEATED RECTAL INFECTIONS AND SYPHILIS INFECTIONS

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10.1136/sextrans-2015-052126.112

Background/introduction Men who have sex with men (MSM) are at higher risk of acquisition of HIV in relation to risk exposure. Health Advisers (HA) have a key role in recognising the indicators of higher risk[1] and reducing this through optimal management.
Aim(s)/objectives Assess documentation of risk reduction discussion and intervention by HAs for MSM with 2 or more episodes of rectal infections in the previous year and /or a diagnosis of syphilis (new or reinfection).
Methods Identified – via the electronic patient record (NASH)- all MSM attending any Clinic (January–June 2014) with 2 or more rectal infections in the previous year and /or diagnosis of syphilis (new or re-infection) Retrospective case note review.
Results N = 19. 15 positive syphilis infections. Four already known HIV positive (One patient received HIV diagnosis at the same time as syphilis). Four repeated rectal infection (all known to be HIV positive). One diagnosed HIV positive between first and second positive rectal infection. Documentation is inconsistent. None had any documentation of referral to a third sector agency or for psychology/ advanced Motivational Interviewing.
Discussion/conclusion Numbers were very small. Lack of documentation does not mean that an intervention or discussion was not carried out. Nonetheless consistent recording aids consultation and demonstrates that all means available, to assist men in reducing risk, have been offered. A risk assessment tool and standards for documentation are being developed in Lothian. HAs are encouraged to consider psychology and advanced behaviour change services early.

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P70 RANDOMISED CONTROLLED TRIAL TO PROMOTE RESILIENCE AND SAFE SEX AMONGST FEMALE SEX WORKERS IN HONG KONG

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10.1136/sextrans-2015-052126.113

Background/introduction Female sex workers (FSWs) are often considered as a vector for HIV and other sexually transmitted infections entering the general communities.
Aim(s)/objectives This study investigated the effectiveness of a resilience-promoting intervention that targets at psychological well-being to facilitate adaptation and safe sexual practices among FSWs which could be an innovative strategy in controlling the spread of these infections.
Methods Using resilience framework, this intervention consisted of six-weekly sessions focused on awareness, expression and management of emotions, identifying roles and personal strengths, and effective problem-solving skills. The primary outcome of resilience and reduction of sexual risk behaviour were assessed at baseline, post-intervention and 3-month follow-ups through self-administered questionnaires. Difference of the differences between the two groups and intention-to-treat analysis were adopted in the analysis.
Results 127 FSWs were recruited and randomly assigned to the intervention or usual care (control) groups in a multi-centred randomised controlled trial. There were significant differences on the score on resilience, self-esteem and general mental health status between the two groups at post-intervention and 3-month follow-ups. The rate of condom use improved with time but significant difference between groups was only observed at 3-month follow-ups. Regression models showed that, after controlling for marital status and family size, intervention group assignment (OR = 2.95, 95% CI: 1.19–7.35) and self-efficacy ($t = 2.48$, $p < 0.05$) was significantly associated with improved resilience scores.
Discussion/conclusion The results suggest that the programme was effective in promoting resilience, self-esteem and the mental health status but with less obvious effect on sexual health among FSWs in Hong Kong.

P71 IMPROVING THE PEP EXPERIENCE FOR PATIENTS

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10.1136/sextrans-2015-052126.114

Background/introduction BHIVA/BASHH have published guidelines with auditable outcomes for initiation of PEPSE and follow up. Some UK centres have, however, reported missing these targets.
Aim(s)/objectives To explore the patient journey from initiation of PEP to completion of follow-up and to identify areas for improvement within our service in supporting patients to take PEP.
Methods Each patient commencing or continuing PEP at our clinic between December 2013 and June 2014 was asked to take part in a survey regarding their experience with PEP. The survey included questions about adherence (motivations and barriers), clinic experience and follow up.
Results 31 patients took PEP during the study period, 26 patients participated in the study. Reasons for PEP included occupational exposure (n = 6), sexual assault (n = 9), and consensual sex (n = 11). 4 patients (15.3%) reported not completing the 28 day course of PEP. 9 (34.6%) and 8 patients (30.7%) reported late and missing doses respectively. 88.4% of patients experienced side effects from medication, only 43% of patients sought help for this. The most frequent motivation for completing PEP was "fear of HIV infection" (69.2%). 69.2% patients identified a specific HCP within clinic as being particularly supportive. Advice regarding remembering to take medication, continuity with HCP and arrangement of follow up appointments at the initial attendance were positively received.
Discussion/conclusion This qualitative survey identified barriers to compliance and ways to support patients in taking PEP. We should encourage patients to contact us for advice regarding side effects and anxiety, and provide practical advice around reminders for medication taking.

P72 INVESTIGATING THE USE OF PRE-EXPOSURE PROPHYLAXIS-A PRELIMINARY ANONYMOUS SURVEY

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10.1136/sextrans-2015-052126.115

Background Pre-exposure prophylaxis (PrEP) has been proven to be biologically effective, and its clinical efficacy continues to be assessed in trials. Data have been published on patient's willingness to take PrEP, but we are unaware whether patients are already doing so outside of clinical trials and how they are sourcing the medication.
Methods A preliminary anonymous questionnaire was offered to HIV negative men who have sex with men (MSM) attending our services. The questionnaire sought to gain basic demographic data, the frequency of condomless sex in the preceding three months, whether participants had heard of PreP, whether they had taken it, and if so, how long for and how they sourced the medication.
Results 80 completed questionnaires were returned. The mean age was 30.6 years. The median number of partners in the last three months was 4 (range 1–55). 49% of respondents had 1–5 episodes of condomless sex in the preceding 3 months and 6% had >10 episodes of condomless sex. The majority of respondents (82%) had heard of PrEP. Five respondents (6%) had taken PrEP: one had been taking part in a clinical trial, three had used post-exposure prophylaxis as PrEP for between 24 and 28 days, and one had used a partner's anti retrovirals for 7 days.
Discussion This preliminary anonymous questionnaire suggests that the majority of HIV negative MSM attending our clinic have knowledge of PrEP. A small number are actively sourcing anti-retroviral medication to use as PrEP outside of clinical trials. We are now expanding this study to reach a higher proportion of our clinic attendees and also to link responses to clinic numbers in order to gain more behavioural information.

P73 THE SOURCE OF THE PROBLEM – RE-AUDIT OF PEPSE PROVISION AT AN INNER CITY SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.116

Background Post exposure prophylaxis following sexual exposure (PEPSE) reduces transmission of HIV. BASHH updated it's guidance on the provision of PEPSE in 2011.
Aim To review provision of PEPSE at an inner city sexual health clinic.
Method Retrospective case note review of patients attending for PEPSE between January and June 2014. Comparison was made

with a previous audit from 2012; following which recommendations were made, including efforts to contact the source patients.
Results A total of 126 patients attended for PEPSE during the 2014 audit period; median age 28 years (range 17–53); majority male (93.7%); homosexual (81.0%); White British (79.4%). Baseline HIV tests were performed in 99.2%; PEPSE was prescribed in accordance with BASHH recommendations in 98.4% and 97.6% were provided <72 h. In 15.1% the source was contacted.

In comparison with our 2012 audit, there were fewer women (6.3% vs 20.6%) who accessed PEPSE and there was an improvement in PEPSE being prescribed in accordance with BASHH recommendations (98.4% vs 92.7%). There was a statistically significant improvement in the number of source patients contacted (15.1% vs 2.9%; $p < 0.01$). In the case of 19 patients in whom the source was contacted, 4 were able to stop taking PEPSE (21.1%).
Discussion/conclusion The number of patients accessing PEPSE has remained high and forms an important part of service provision in sexual health clinics. Contacting the source is an important step to reduce the unnecessary prescribing of PEPSE.

P74 POST EXPOSURE PROPHYLAXIS: BASHH REGIONAL AUDIT 2014

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10.1136/sextrans-2015-052126.117

Background/introduction In 2011 British Association of Sexual Health and HIV (BASHH) updated their guidelines on HIV post-exposure prophylaxis (PEP).
Aim(s)/objectives To audit the management of patients treated with PEP for both sexual and non-sexual risk in GUM clinics against BASHH PEP guidelines.
Methods A retrospective case notes review was performed on patients attending for PEP following both sexual and non-sexual risk, in 7 GUM clinics in Wessex between January–December 2013. Data collected included indication for PEP, time to commence, STI screening, completion rates and HIV testing done at baseline and 3 months post-PEP.
Results 98 case notes were reviewed. 77 patients had a sexual risk (47/77 men who have sex with men) and 21 a non-sexual risk. 92% of patients had a baseline HIV test at <72 h (target 100%). 73% of PEPSE prescriptions fitted within recommended indications, however only 28% of PEP prescriptions following non-sexual risk fitted within the recommended indication (target 90%). 100% of patients received PEP within 72 h and 62% of patients completed 4 weeks PEP (target 75%). 54% of patients had an HIV test at 3 months post-PEP (target 60%) and 70% of patients receiving PEPSE had an STI screen (target 90%).
Conclusion This audit demonstrated some good management such as baseline HIV testing and the time to commence PEP. It also revealed areas to be improved, in particular PEP prescribing in a non-sexual risk situation, where often the risk was not a recommended indication. This highlights the importance of continued education to all PEP prescribers.

Category: HIV testing, new diagnoses and management

P75 PATIENT SATISFACTION WITH HOME DELIVERY SERVICE FOR ANTIRETROVIRAL MEDICATION

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10.1136/sextrans-2015-052126.118

Background/introduction There is much interest in the use of home delivery services for antiretroviral medications. Advantages include convenience for patients, but notably, being VAT exempt, considerable cost benefits. In a small clinic like ours (cohort 174 patients), the estimated annual saving is £85,000. Disadvantages include concerns about confidentiality and inconvenience.
Aim(s)/objectives To assess the level of patient satisfaction with homecare delivery with a goal of 90%, and to exclude 'never events': delivery to wrong person/address or patient running out of medication.
Methods Between April and July 2014 we conducted an opportunistic paper-based survey of patients attending the HIV clinic. Results were analysed using Microsoft excel.
Results Completed questionnaires were returned from 57% of all homecare users. 85% reported telephone contact was good or very good but 23% experienced failure to deliver within the agreed time slot, some on multiple occasions. One patient reported running out of treatment and two deliveries had been made to an incorrect address. Overall satisfaction with the service was 81%.
Discussion/conclusion This survey had a number of limitations: it was not completely randomised or anonymised, used subjective measures, did not account for patient compliance and did not explore reasons for declining homecare. Overall satisfaction with the service fell short of our goal of 90%. More importantly there were 3 'never events', two of which involved potential breach of confidentiality and caused considerable distress to the patients. The results have been fed back to the homecare delivery provider with a particular focus on avoiding 'never events'.

P76 STI SCREENING IN HIV POSITIVE PATIENTS ATTENDING A CITY-CENTRE HIV CLINIC

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10.1136/sextrans-2015-052126.119

Background/introduction STI screening and treatment of HIV infected individuals is essential for the health of each individual and to prevent onward HIV transmission.
Aim(s)/objectives To audit STI screening among our HIV cohort against 2007 BHIVA, BASHH, and FSRH guidelines on management of SRH of people living with HIV.
Methods Case notes of the first 150 patients attending from 1 January 2014 were reviewed. Data gathered included: Demographics, sexual history taking in the last 6 months, STI screening in the last 12 months and STI diagnoses.
Results 54 patients were female (36%) and 96 male (64%). Average age was 43 (range 17–71). 81 patients (54%) were White British, 53 (35%) Black African. 95 (63%) patients were heterosexual, 53 (35%) gay, and 2 (1%) bisexual. Demographics were representative of the whole cohort (444 patients). Sexual history was documented for 121 patients (81%) in the last

6 months, 78 (64%) reported being sexually active. 14 (12%) reported at least 1 new partner in the last year. 52 (35%) were offered STI screening in the last year and 32 accepted (62%). 9 (28%) were diagnosed with STI(s): Gonorrhoea, chlamydia, warts, LGV, syphilis and hepatitis C. Those reporting partner change were more likely to be diagnosed with STI(s) (58% of those screened vs 10% not reporting partner change, p = 0.002).
Discussion/conclusion A high prevalence of STIs was observed. Sexual history taking is essential to identify those most at risk. However, STIs were diagnosed in those reporting no partner change, supporting routine STI screening among our cohort.

P77 UNDIAGNOSED HIV: CAN AT RISK GROUPS BE IDENTIFIED FOR A NEW TESTING STRATEGY?

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10.1136/sextrans-2015-052126.120

Background/introduction Public Health England report (Nov 2014) the number of HIV tests is increasing, number of positive diagnoses decreasing, but proportion undiagnosed HIV unchanged. We aimed to suggest new local strategy. Demographically identifying late diagnoses (CD4 <350 cells/mm^3) would find groups within the population more likely to be diagnosed late. Testing that group could uncover undiagnosed early HIV.
Methods Data gathered about HIV diagnosed in our city Jan 2009–Dec 2014: age, gender, ethnicity, orientation, previous test, indication, place tested. Chi-Square compared early/late diagnoses. Under-served compared to well-served demographics.
Results 251 new diagnoses in 5 years. 125 early, 126 late. Disproportionate late diagnoses:

- females (p = 0.023) without previous test (p = 0.006)
- HSM (heterosexual males) (p = 0.068) without previous test (p = 0.004)

No significant difference between early/late diagnosis:

- ethnicity: Caucasian, sub-Saharan African, other (p = 0.103)
- age: <50 vs >50 (p = 0.74)
- bisexual males (p = 0.87)

Disproportionate early diagnoses:

- MSM males (p = 0.032) with previous test (p = 0.052)

Abstract P77 Table 1 HIV testing

	Females	HSM no prev test	MSM
Total	48	37	119
Median age	34 (20–64)	43 (22–76)	35 (17–66)
Median CD4	221 (8–941)	177 (2–718)	419 (8–1003)
Indications	Antenatal testing 8/48	Partner positive 7/37	SH screen asymptomatic 34/119
	Partner positive 7/48	Respiratory illness 7/37	SH screen symptomatic 17/119
			Partner positive 17/119
Place	GUM 13/48	Secondary care 15/37	GUM 59/119
	GP 10/48	GP 9/37	GP 19/119
	Secondary care 10/48		GUM outreach 14/119

Discussion/conclusion Barriers to earlier self-presentation of females and HSM should be examined. MSM benefit from specialised clinics yet are <50% diagnoses. Likely public and clinician unawareness of risk excludes earlier testing.

P78 IS ROUTINE HIV TESTING BY NURSING STAFF ADMITTING PATIENTS TO HOSPITAL FEASIBLE?

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10.1136/sextrans-2015-052126.121

Background/introduction Routine HIV testing in acute medical admissions is recommended in areas of high HIV prevalence. A local sero-anonymous prevalence study suggested high rates of undiagnosed HIV in both medical and surgical admissions. We have developed a successful non-clinician based model of HIV testing using a dedicated Health Care Assistant (HCA) in medical admissions. We are keen to move back to clinician-based HIV testing using the HCA as a testing-facilitator offering education and a bespoke HIV testing training resource to support HIV testing. This model will allow roll-out of HIV testing to all admissions.
Methods A service evaluation through purposive sampling to assess whether nursing staff would be willing to perform routine HIV testing and to pilot the HIV testing training resource.
Results 10 nurses from the Emergency Department, Acute Medical Unit, and medical wards responded. 4/10 felt that current coverage (a single HCA) was inadequate. 8/10 said they would be willing to routinely test admissions for HIV provided support and training from the HIV Screening HCA was given, especially around the informed consent process. 1/10 suggested that routine screening would make discussing HIV testing less awkward. 8/10 felt the training resource was comprehensive and helpful.
Discussion/conclusion This pilot suggests that Routine HIV testing by nursing staff admitting patients is feasible with the support of an HIV testing facilitator and an HIV testing training resource.

P79 HIV MONITORING AND INVESTIGATIONS, AN AUDIT SERIES: USE OF VISIT THEMED PROFORMAS TO IMPROVE CARE

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10.1136/sextrans-2015-052126.122

Background Recommended HIV routine monitoring and investigations in the outpatient setting has become increasingly extensive. HIV clinics use different methods including proformas to record consultation visits. Due to time constraints, in a busy clinic, the recommended monitoring and investigations can be overlooked.
Aim To raise standards of monitoring and investigation of HIV attendees by reviewing our clinical proformas.
Method Three annual retrospective case notes review of 50 to 53 patients with HIV attending service for HIV related care. Standards were set based on national BHIVA standards. In 2011 an annual proforma was introduced, which was updated in 2012 to meet the BHIVA 2011 monitoring guidance. However, the annual visit was then long and time constraining, so in 2013

monitoring across three themed visits every 4 months was created using three new proformas.
Results In 2011 smoking history, vaccinations, alcohol use, STI screening and mental health issues were poorly documented failing to meet standards. There was an overall improvement in those areas in 2012 with the updated proforma and continued improvement when three themed visits were created (smoking 37% to 96%, alcohol use 35% to 88%, and Influenza vaccine recommendation 63% to 94%). Areas with initial higher results such as cardiovascular risk and urinalysis achieved even higher outcomes (80% to 100%, 92% to 96% respectively).
Discussion Updating proformas to produce three themed reviews each year increased standards further in most areas and has had a positive effect on the HIV clinic with staff stating it feels less rushed, feels more focused and easier to keep to time.

P80 WOULD YOU LIKE A HIV TEST?

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10.1136/sextrans-2015-052126.123

Background Opt out HIV testing has been a policy in our sexual health clinic for over 10 years. In 2010, in the UK, 78% of those attending a sexual health clinic were offered a HIV test, in our clinic among women was 69%.
Aim To evaluate and describe the patients who did not have a HIV whilst attending our sexual health clinic.
Method A retrospective case note review of women who did not have a HIV test between 1/1/14 to 31/3/14.
Results 197 females were identified (age range 13–63 years, with a mean, median and mode of 38, 20 and 18 years). Ethnic distribution was 69% White, 12% Black, 9% Asian, and 10% other ethnic backgrounds. 131 (66%) attended for a STI screen, 28 for contraception, 35 for both, and 4 with other problems. 33 patients refused to have a HIV test; however 150 (76%) cases had no documented reason for not performing a HIV test. Other reasons documented include: negative HIV test in past 4 months (2%), incubation period discussed/patient to return (2%), needle phobia (1%), no sexual contact (1%) and failed phlebotomy (0.5%). 182 (92%) had a NAAT test for chlamydia and gonorrhoea. There were 15 identified cases of chlamydia, 2 with chlamydia and gonorrhoea, and 1 case of gonorrhoea.
Conclusion Only 47 (23%) patients had a documented reason for refusal of HIV testing, however more commonly no reason was documented. We plan to present these findings to our department for discussion aiming to improve opportunistic HIV testing.

P81 AUDIT OF HIV TESTING IN A LYMPHOMA CLINIC

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10.1136/sextrans-2015-052126.124

Background/introduction Non-hodgkins lymphoma (NHL) is the second most common malignancy in those with HIV, and AIDS related lymphomas (ARL) have increased as a percentage of first AIDS defining illness (ADI). Hodgkins lymphoma (HL) is a non AIDS defining malignancy but has 10 to 20 times higher incidence in those who are HIV positive. To assist in reducing late diagnosis of HIV, BHIVA guidelines in 2014 highlighted diseases where an HIV test should be offered including NHL and HL.
Aim(s)/objectives To establish whether patients newly diagnosed with NHL or HL in a large district general hospital lymphoma clinic were being tested for HIV in accordance with national and local guidelines.
Methods Patients newly diagnosed with NHL or HL from January 2013–January 2015 were identified via positive histology results recorded by the laboratory. Identification of HIV testing was via electronic blood results records.
Results

Abstract P81 Table 1 HIV testing in lymphoma

Year	Number of new lymphoma diagnoses	Number tested for HIV	Number positive HIV results
2013	61	12	0
2014	55	39	0
2015 (Jan)	1	1	0

Discussion/conclusion Local haematology guidelines from 2014 indicate HIV and HCV/HBV testing for patients prior to Rituximab chemotherapy for lymphoma. The results indicate that since implementing guidelines, more HIV testing occurred, but without an increasing identification of undiagnosed HIV. A 2003 study investigating HIV positivity in newly diagnosed NHL identified HIV positive patients had more aggressive lymphoma histology and increased B symptoms. Continued testing for HIV in lymphoma, especially if presenting with B symptoms, is recommended.

P82 FACTORS ASSOCIATED WITH DELAYED DIAGNOSIS IN HIV LATE PRESENTERS

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10.1136/sextrans-2015-052126.125

Background/introduction Despite presenting indicator conditions, HIV diagnoses are often delayed resulting in higher mortality and morbidity.
Aim(s)/objectives To review the rate of late HIV diagnosis locally and identify factors associated with delayed diagnosis.
Methods Retrospective GUM and hospital case note review of all 31 newly diagnosed HIV patients attending the Norwich GUM clinic in 2013.
Results 12/31 (38%) were late presenters with CD4 count persistently below 350 cells/mm^3. At diagnosis 3/12 had no symptoms or indicator conditions; 2/12 had symptoms that were immediately acted upon; 7/12 had indicators illnesses not acted upon in a timely fashion hence the diagnoses were delayed from between 2 months to 2 years. Of these 7 delayed diagnoses 2 presented to GUM and declined testing initially although they were men who had sex with men (MSM). 5/7 presented as acute admissions; 3 were MSM (2 bisexual), 1 heterosexual male and 1 female. All of the 5 patients presenting with acute admission had medical associations; one was a nurse, 4 had immediate family members or a partner who was a nurse, doctor or pharmacist. The mean age of the male patients who were diagnosed in hospital was 65 years (range 52–80 years).
Discussion/conclusion HIV testing may be less likely to be undertaken for older inpatients and those with medical associations.

P83 A CASE OF HIV ASSOCIATED NEUROCOGNITIVE IMPAIRMENT (HAND) RESPONDING TO HAART SWITCH

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10.1136/sextrans-2015-052126.126

Background/introduction We describe a case of a 34 yr old Black African women fully suppressed on HAART for 9 yrs presenting with recurrent episodes of HIV encephalopathy with abnormal MRI brain scan and detectable HIV in CSF. Following ARV switch her cognitive function and scans had improved and remains undetectable in CSF.
Aim(s)/objectives Started HAART in 2005 and remained asymptomatic and fully suppressed on (Kivexa/Atvr/rit) CD4 > 500 mm. Presented initially in 2014 to Neurology with acute confusion, headaches and convulsions. CSF revealed pleocytosis with V/L 811 copies and neg for infective screen. MRI scan revealed diffuse non-specific signals consistent with HIV encephalopathy. On recovery she was monitored in clinic and remained virologically controlled but with residual neurocognitive impairment characterised by short term memory loss and difficulty concentrating. She then represented 9 months later with focal motor signs and confusion resolving within 48 hrs MRI scan no focal lesion. Rpt CSF revealed V/L of 960 copies.
Results In view of persistant CSF viraemia she was switched to higher CPE score (from 7 to 12) HAART regimen of Trizivir/Maraviroc. Subsequently she fully recovered cognitive function and rpt CSF at 3/12 confirmed full suppressed VL with resolving brain scan.
Discussion/conclusion This case demonstrates that in well controlled pts on HAART who develop presumptive neuro-HIV and in absence of other potential causes, the value of CSF V/L in in constructing a HAART regimen with improved CSF penetration can result in significant improvement in both clinical and objective markers such as MRI scans.

P84 NATIONAL HIV TESTING WEEK 3: FINDING THE HARD TO REACH AND BUILDING ON SUCCESS

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10.1136/sextrans-2015-052126.127

Background/introduction The third National HIV Testing Week (NHTW) was in November 2014.
Aims To build on our previous success of testing the most-at-risk populations (MARP), focusing on outreach.
Methods A third sector organisation, primarily targeting gay communities, provided club and bar outreach and offered point-of-care testing (POCT) on-site and at 2 saunas. A second third sector organisation, targeting African communities, offered POCT at 6 venues, including local markets, an asylum-seeker centre, pharmacies, health centres and an African football match. CASH services offered POCT at 3 clinics across the city. GUM and Leeds City Council staff volunteered to provide outreach and testing support for the 12 different testing sites across the city.
Results 167 people tested (126 in 2013, 94 in 2012). 71% were from MARPs, unchanged from 2013. 1 female black African and 1 MSM tested HIV+ve, the first HIV diagnoses resulting directly from NHTW initiatives in our city. 74% of people who tested were sensitised through community outreach. Over 90% of people tested were given advice on PEP, repeat testing, STI screening and offered condoms.
Discussion Two undiagnosed HIV+ve people were identified as a result of NHTW efforts, and both are now in HIV care. A greater population, including those from MARPs tested. Of the MARPs, a higher percentage were testing for the first time. This may reflect decreased overall testing in MARPs, or that our NHTW 2014 campaign was more successful at reaching and testing people who are less likely to attend more traditional testing sites.

P85 HIV TESTING IN A RURAL SCOTTISH HEALTHBOARD – HAS ANYTHING CHANGED?

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10.1136/sextrans-2015-052126.128

Background/introduction Forth Valley NHS Health board is in central Scotland, covers a land area of 2633 km^2 and looks after approximately 300,000 people. Education to healthcare professionals in different formats to try to increase HIV testing in those with relevant indicator conditions, in routine sexual health screens and in those from higher risk populations have been more frequent and visible in the last few years.
Aim(s)/objectives We were keen to see if this had resulted in a change in testing.
Methods A laboratory report showing the requesting location all HIV tests performed in 2012 and 2014 was produced. New HIV diagnoses attending the local HIV service and where they had been diagnosed was also recorded.
Results Overall a 19% increase in testing in 2014 compared to 2012.

Abstract P84 Table 1 National HIV testing week 2014

	Total testing		1st ever HIV test		If previously tested, last test >1 yr ago		PEP aware		Previously attended GUM		Reactive test	
	2013	**2014**	2013	**2014**	2013	**2014**	2013	**2014**	2013	**2014**	2013	**2014**
Black African	27	**49**	19%	**29%**	55%	**43%**	19%	**20%**	36% (9/25)	**27%**	0	**1**
MSM	61	**70**	39% (21/54)	**47%**	39%	**35%**	32%	**50%**	46% (26/57)	**47%**	0	**1**
Total	88	**119**	32%	**40%**	45%	**24%**	28%	**38%**	43%	**39%**	0	**0.02%**

Abstract P85 Table 1 HIV testing in Rural Scotland

Testing Location	2012	2014
Antenatal	3583	3427
Sexual health	2668	3281
General Practice	425	890
Ward mix	288	209
Gastoenterology outpatients	305	357
Renal	206	261
Occupational health	230	244
Termination of pregnancy	253	247
Prisons	340	594
General outpatients	34	20
Rheumatology	10	103
Haematology	31	74
Emergency department + Acute Assessment Unit	51	64
Addiction services	64	267
Paediatrics, ENT, Respiratory, Cardiology, Gynaecology, ICU, Mental health, Maxillofacial, Neurology, Ophthalmology, Orthopaedics, Dermatology, Needlestick source testing	70	147
Total	8558	10185

In 2012 there was one new HIV diagnosis, this was in the sexual health service. In 2014 there were four new diagnoses, two in sexual health and two in ENT.

Discussion/conclusion This work has been helpful to show where HIV testing is being performed. This work allows us to target specific departments and encourage relevant testing and optimise patient testing pathways. We plan to repeat this work as we are aware of current initiatives in several departments such as the acute admission unit. We will also compare our results with the four other health boards through the West of Scotland sexual health MCN. In future work we will also be able to look at 'Reasons for testing' as this will be clearly recorded using the new test order system.

P86 AN AUDIT OF TIME TAKEN TO REACH UNDETECTABLE VIRAL LOAD IN THERAPY-NAÏVE HIV-POSITIVE PATIENTS INITIATING ART

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10.1136/sextrans-2015-052126.129

Background The primary aim of antiretroviral therapy (ART) is to reduce morbidity and mortality due to chronic HIV infection. Central to ART is viral suppression, and this has been used as a proxy for disease burden. BHIVA guidelines recommend that patients achieve undetectable viral loads (<50 copies/mL) within 6 months of initiating ART.

Aim To assess the proportion of patients achieving undetectable viral loads within 6 and 12 months of initiating ART at a dual-site HIV service in Grampian.

Methods A retrospective case notes review was conducted of HIV-positive patients attending clinics between January 2013 and December 2013. Data was collected using a standardised proforma and imported into SPSS 23 for statistical analysis.

Results Twenty-four case notes were audited (GUM = 15, ID = 9). The median age of patients was 39.5 years. Median baseline viral load and CD4 count were 77,355 copies/mL and 382 respectively. Overall, 70.8% of patients achieved undetectable viral load within 6 months and 95.8% achieved undetectable viral loads within 12 months (mean = 4.48 months, 95% CI = 3.50–5.70). A Kaplan-Meier survival analysis showed that patients with a baseline viral load of <100,000 copies/mL achieved undetectable viral load sooner compared to those with >100,000 copies/mL (3.43 months, 95% CI = 2.34–3.66 vs. 6.11 months, 95% CI = 4.28–7.94; log-rank p = 0.013).

Conclusion This audit has identified potential barriers to viral suppression, such as late diagnosis and late commencement of ART. These areas must be addressed to ensure the target of 75% of patients with an undetectable viral load within 6 months of initiating ART can be achieved.

P87 USE OF POCKET-SIZED HIV TESTING GUIDELINE CARDS TO INCREASE HIV TESTING IN MEDICAL INPATIENTS

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10.1136/sextrans-2015-052126.130

Background/introduction HIV is a chronic treatable condition with an excellent prognosis. There remains, however, a high morbidity and mortality due to late diagnosis, with approximately 1 in 4 HIV patients unaware of their condition. Healthcare professionals have previously seen many of these patients without the diagnosis being made. Rotherham's HIV prevalence is 1.05 per 1000. Late diagnosis made in 56%.

Aim(s)/objectives To increase HIV testing in general medical inpatients.

Methods We obtained a list of all medical inpatients in March 2014 who had been coded with a condition that should prompt HIV testing in accordance with BHIVA 2008 guidance.

We reviewed the number of HIV tests requested on medical inpatients during the 1-month period. In June 2014, we delivered a presentation at the Medical Grand Round and two subsequent teaching sessions for staff on HIV testing. We produced a pocket-sized card for staff to attach to the back of their ID badges listing the indications for testing. We compared the proportion of HIV tests performed before and after this intervention.

Results In March 2014, there were 69 patients with clinical indicators for HIV testing. Of those 32 were tested (46.4%). In June 2014, following the intervention, there were 58 patients with clinical indicators and 40 (69.0%) of those were tested.

Discussion/conclusion Following our educational intervention, almost 70% of patients were tested appropriately representing a 22.6% increase from baseline. We plan to re-measure this at a later date to assess whether this increase in uptake of testing has been sustained.

P88 ROUTINE HIV TESTING IN ACUTE GENERAL MEDICINE USING A NON-PHYSICIAN IMPLEMENTED MODEL

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10.1136/sextrans-2015-052126.131

Background/introduction UK national guidelines recommend routine HIV testing in general medical admissions and primary care in areas where the HIV prevalence exceeds 2/1000 in the local population. The guidelines recommend further operational research to assess the feasibility and efficacy of different

approaches to routine testing. A recent study showed that when a physician led model of testing is in place, 39.7% of all general medical patients are offered HIV tests.
Aim(s)/objectives Assess the feasibility and acceptability of a non-physician directed (NPD) model of HIV testing.
Methods Retrospective cohort study involving a review of the proportion of all medical admissions offered tests by a NPD model of HIV testing.
Results 57.9% (1973/3409) of all general medical admissions aged 18–79 were offered HIV tests. Acceptability was high with 96.7% (1908/1973) of offered patients having HIV tests. The mean age of patients offered and tested was 56.8 years.
Discussion/conclusion This study demonstrates superior feasibility and efficacy of a non-physician directed model of routine HIV testing. Although cost and culture remain important barriers of employing this strategy in many hospitals, the use of allied health professionals may be an important step in achieving National and International guidelines for HIV testing.

P89 DISCUSSION OF PARTNER NOTIFICATION, HIV TRANSMISSION, MEDICO-LEGAL ISSUES AND VOLUNTARY SECTOR SUPPORT AT FIRST HIV SPECIALIST REVIEW: AUDIT REPORT

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10.1136/sextrans-2015-052126.132

Background/introduction BHIVA testing guidelines recommend that partner notification, transmission of HIV and the medico-legal issues are discussed with patients at their first review with an HIV specialist. This should ideally occur within 48 h but no later than 2 weeks after diagnosis. Consideration of additional support from the voluntary sector is also advised.
Aim(s)/objectives To audit the documentation of the recommendations above.
Methods A retrospective audit of electronic clinic letters and paper records of all HIV patients diagnosed at our service between 01/2008–04/2014.
Results Overall, 182/187 (97%) had all the information discussed with them and documented in the notes. In 2008, three patients had missing information. One failed to return following a positive test so all information was missing. One had no record of voluntary sector discussion. One was missing information about transmission and medico-legal issues. In 2011, another patient tested positive and failed to return for review so all information was missing. In 2013, one patient had a missing record of medico-legal issues discussion. In all other years all information was discussed and recorded in patient records.
Discussion/conclusion Each of the recommendations were discussed and documented in nearly all cases, with an improvement noted after 2008 (the year the guidelines were published). Each recommendation has important public health implications with the potential to reduce onward transmission. The provision of voluntary sector information is crucial for providing patients with additional support during the challenging time following diagnosis and has the potential to impact on future retention in care.

P90 HOSPITALISATION IN HIV PATIENTS: ARE THE CAUSES OF ADMISSION CHANGING?

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10.1136/sextrans-2015-052126.133

Background With an ageing HIV cohort and increasing use of antiretroviral (ART) therapy it may be expected that HIV associated morbidity causing hospitalisation is changing.
Aim To describe hospital admissions over 2 years, and compare this to 2006 data to ascertain if there has been any change.
Methods Retrospective case review of HIV admissions during 2013–14. Patient diagnoses were classified as AIDS related, HIV related, ART toxicity related, and non-HIV related, with one main admission diagnosis.
Results 286 patients were hospitalised during 2013–14, accounting for 458 admissions. Mean age was 48 years, and 71% (203/286) of patients were on ART on admission. 35% (99/286) patients were admitted more than once in the same calendar year. CD4 count was <200 cells/mm^3 in 25% of admissions. 15% (69/458) were admitted for AIDS related causes compared with 20% reported in our 2006 data ($p = 0.23$). Pneumocystis pneumonia (PCP) was the commonest diagnosis, comprising 33% (23/69) of AIDS admissions. 40% (185/458) of admissions were HIV related, including bacterial causes which accounted for 31% (142/458) of all admissions. Non-HIV causes accounted for 45% (204/458) of hospitalisations. There were no admissions for ART toxicity.
Discussion The number of admissions in HIV patients remains high, with a fifth of patients severely immunocompromised on admission. Although admissions secondary to AIDS-defining diagnoses have decreased this is not statistically significant. There is a need to improve strategic HIV testing to prevent late diagnosis and AIDS related conditions, with increased promotion and access of testing in non-GU settings.

P91 HIV IN SCOTLAND: PREDICTING THE NUMBER OF PEOPLE WHO ARE UNDER CD4 MONITORING AND RECEIVING ANTIRETROVIRAL THERAPY

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10.1136/sextrans-2015-052126.134

Background/introduction The number of people living with HIV in Scotland has increased in recent years as a result of the widespread use of antiretroviral therapy, improvements in testing, inward migration and new infections. Since these increases are expected to continue, it is imperative that HIV specialist care services understand how the number of people requiring care is going to change over time.
Aim(s)/objectives To predict the number of HIV positive individuals who are under CD4 monitoring (and thus in HIV specialist care) and receiving ART in Scotland for 2013–2020.
Methods Using CD4 monitoring data collected in Scotland for 2007–2012 we develop a statistical model that groups the HIV infected population into several categories depending on their CD4 count and ART status. The model is based upon a Markov

process which predicts the status of individuals in year i+1 from their status (category) in year i. Historical data is used to estimate the transition probabilities which are modelled using a multinomial trend model. Confidence intervals are calculated using boot strap procedures.

Results By 2020 there will be a 54% increase in the number of individuals who are receiving ART and a 42% increase in the number of individuals under CD4 monitoring. Results for individual HIV risk groups predict increases of at least 34%, 77% and 35% for heterosexuals, people who inject drugs and men who have sex with men, respectively.

Discussion/conclusion With such large increases in the number of people who are under CD4 monitoring and receiving ART, NHS boards will need to plan ahead to ensure they have adequate resources to treat those in need.

P92 A COMPARISON OF BLOOD AND SALIVA SAMPLING FOR HOME HIV TESTING

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10.1136/sextrans-2015-052126.135

Background HIV home sampling offers an acceptable and convenient method for HIV testing and may provide a practical solution for increasing testing in high risk groups. However, we are unaware of any data comparing the effectiveness of different sampling methods. From August 2013 users of our online HIV testing service were offered an informed choice between blood and saliva HIV sampling.

Method We interrogated the database of all HIV home sampling requests and analysed any differences in demographics and return rates for both blood and saliva samples.

Results Between 15.8.13 and 31.11.14, 14312 home tests were requested. Blood tests were preferentially chosen (9532, 66.6% vs 4780, 33.4%). 7257 samples (50.7%) were returned, this encompassed 4758 blood samples and 2499 saliva samples (49.9% of requested blood samples vs 52.2% of requested saliva samples $p = 0.01$). The service is predominantly aimed at men who have sex with men and of the returned samples the majority were from men (6416, 84.7%) Men were significantly statistically more likely to request blood samples than women (67% vs 51%, $p < 0.00001$). In total there were 123 reactive samples (1.7%, 116 men, 7 women), 82 from blood samples (77 men, 5 women) 41 from saliva (39 men, 2 women).

The average age of all requests was 30.3 years, 30.8 years in persons who returned samples and 29.7 years for those who did not ($p < 0.00001$). There was a significant difference in the ages of people requesting saliva versus blood samples (29.7 years vs 30.6 years $p < 0.0001$). The average age of persons with negative samples was 30.8 years vs. 33.0 years in those with positive samples ($p < 0.05$). The median number of days from when the sample was ordered to when it was collected back was 6 days in all groups (negative samples, reactive samples, men, women, blood and saliva).

Discussion Despite being more invasive when given an informed choice, more people chose blood over saliva sampling. However saliva samples were more likely to be returned. Women were statistically more likely than men to choose saliva sampling. There was no difference in the length of time it took to return reactive and negative samples.

P93 HIV TESTING IN AN INTEGRATED SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.136

Abstract P93 Table 1 Summary of SHHAPT code data for HIV testing uptake

Patient group	Codes	Week 1	Week 2	Week 1 and week 2 comparison
Total sample population N = 205		**N = 114**	**N = 91**	
	P1A + T4	61.4%	65.9%	4.5% increase
	P1B	25.4%	23.1%	2.3% decrease
	P1C	13.2%	11%	2.2% decrease
Total GU presentations N = 126 (61%)		**N = 72**	**N = 54**	
	P1A + T4	76.4%	87%	10.6% increase
	P1B	18.1%	11.1%	7% decrease
	P1C	5.6%	1.9%	3.7% decrease
Total contraception presentations N = 67 (33%)		**N = 33**	**N = 34**	
	P1A + T4	30.3%	29.4%	0.9% decrease
	P1B	42.4%	44%	1.6% increase
	P1C	27.3%	26.5%	0.8% decrease
Total combined GU and contraception presentations N = 12 (6%)		**N = 9**	**N = 3**	
	P1A + T4	55.6%	100%	44.4% increase
	P1B	22.2%	0%	N/A
	P1C	22.2%	0%	N/A
Comparative percentage accepting and declining HIV tests in GU v contraception sub-groups	**P1A + T4 (accept)**			GU = 81% Contraception = 30%
	P1B (decline)			GU = 15.1% Contraception = 43.3%

SHAAPT HIV codes:
T4 + P1A = HIV test done
P1B = HIV test offered + declined
P1C = HIV test inappropriate

Background/introduction National standards recommend eighty percent of new sexual health patients should have an HIV test. Thames Valley data from 2013 highlighted lower uptake of HIV testing in the region's only integrated sexual health service (SHS) compared to two local non-integrated services.
Aim(s)/objectives This audit measured differences in HIV testing uptake between genitourinary (GU) and contraception consultations in an integrated SHS and assessed the impact of a publicity campaign.
Methods SHHAPT codes and demographics were collected from all *new* patients over two weeks; non-coded patients were excluded. Retrospective case-note review differentiated GU from contraception presentations. 'National HIV testing week' posters were displayed in week 2. Data were analysed in Microsoft Excel.
Results Total sample size was 205 patients (week 1, N = 114, week 2, N = 91). 63% were female and 96% heterosexual. Age range was 14 to 83 (mean 31, standard deviation 13), with 36 countries of birth. Patients presented for GU issues (N = 126; 61%), contraception (N = 67; 33%) and combined (N = 12; 6%). HIV uptake differed between GU and contraception groups (81% v 30%). Between weeks 1 and 2, testing uptake increased by 4.5% in the total population and 10.6% in the GU group with minimal change in the contraception group.
Discussion/conclusion HIV testing uptake is higher in GU presentations compared to contraception presentations. This large discrepancy impacts overall testing figures. A publicity campaign may have increased GU uptake but had no impact on contraception consultations. Targeted education and opt out testing should be considered in integrated services.

P94 MORTALITY IN HIV POSITIVE PATIENTS IN A LARGE INNER CITY TEACHING HOSPITAL

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10.1136/sextrans-2015-052126.137

Background/introduction With the advent of highly active antiretroviral therapy (HAART) mortality among HIV positive patients has fallen significantly. Mortality review is important to target care and interventions appropriately.
Methods We reviewed mortality data from 2013 to 2014 for patients under the care of the HIV team at an inner city teaching hospital. There were 39 deaths in our cohort of 3400 patients.
Results Our cohort matched demographic data for people living with HIV in the UK in most respects: male to female ratio was approximately 7:3, 56% were Caucasian, 33% Black African. 21% of patients had acquired HIV via intravenous drug use (although only 2% of people living with HIV nationally are drug users). 28% were men who have sex with men. The median age of death was 47. The most common cause of death was malignancy (44%) followed by sepsis and ischaemic heart disease. Those with a CD4 count <200 at diagnosis survived on average 5.7 years before death. Those with a CD4 count >200 at diagnosis survived 9.7 years on average.
Discussion/conclusion In the post-HAART era, the majority of deaths in people with HIV are not HIV related. Nine patients, however, had an AIDS defining malignancy and three had active opportunistic infections. In the era of HAART, screening for chronic disease and malignancy is vital. Our data suggest that intravenous drug use is a significant factor in people dying at a younger age with HIV. There remains a correlation between late diagnosis and increased risk of death.

P95 THE ABILITY OF THE ALERE™ HIVCOMBO POINT-OF CARE TEST TO DETECT ACUTE HIV INFECTION

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10.1136/sextrans-2015-052126.138

Background/introduction Detection of acute HIV infection is important in preventing HIV transmission and for consideration of early antiretroviral therapy. Fourth generation (4G) HIV tests detect p24 antigen and HIV antibody and should detect acute HIV infection prior to the development of antibodies. An early version fourth generation (4G) point-of-care (POCT) test demonstrated low levels of sensitivity for p24Ag.
Aim(s)/objectives To assess the ability of the new Alere™ HIV Combo 4G POCT to detect p24 antigen in patients with laboratory confirmed p24 antigenaemia.
Methods P24 antigen positive serum samples were tested using the Alere™ HIV-Combo POCT and read at 20 and 40 min. One sample gave an invalid result and was excluded. P24 antigen levels from the VIDAS quantitative HIV p24 11 assay, used as routine HIV confirmatory tests by our laboratory, were recorded for comparison.
Results Twenty-four out of 27 samples (89%) were p24 antigen positive at 20 min and 25/27 (93%) samples were positive at 40 min. There were two false negative samples, shown to have the lowest levels of p24 antigen (27.6 and 8.3 pg/ml) of the 27 samples. The mean p24 antigen level with the VIDAS quantitative HIV p24 11 assay for the cohort was 236.2 (Range 8.3->400 pg/ml). The Alere™ HIV Combo POCT detected all P24 antigen at levels >30 pg/ml.
Discussion/conclusion The Alere™ HIV Combo POCT has 89% sensitivity for p24 antigen at 20 min and 93% at 40 min. These preliminary results suggest that the new Alere™ HIV Combo POCT may be able to detect early infection adequately.

P96 ACCESS OF LEVEL 2 SEXUAL HEALTH SERVICES BY MEN WHO HAVE SEX WITH MEN: WHO GOES AND WHAT SERVICES DO THEY GET?

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10.1136/sextrans-2015-052126.139

Background Men who have sex with men (MSM) bear a disproportionate burden of sexually transmitted infections (STIs) including HIV. While routine STI surveillance data indicate MSM regularly access genitourinary medicine (GUM) services for their sexual health care, the extent to which MSM attend non-specialist Level 2 sexual health services is unclear. We investigated access of Level 2 services by MSM in England.
Methods We used provisional data from the GUM Clinic Activity Dataset (GUMCADv2) to compare the characteristics, service usage and outcomes between MSM accessing GUM and Level 2 services who reported data in 2013.
Results Of all male attendances where sexual orientation was recorded, 12.3% (6,957/57,048) of Level 2 attendances were among MSM compared to 26.3% (299,456/1,139,424) of GUM attendances ($p < 0.001$). MSM attending Level 2 compared to

GUM services, were younger (mean age: 30.5 yrs vs 38.5 yrs; p < 0.001), and more likely to be of black ethnicity (6.8% vs 4.1%; p < 0.001) and reside in London (49.9% vs 46.0%; p < 0.001). MSM attending non-GUM services were more likely to have a full sexual health screen (41.4% vs 27.0%; p < 0.001), HIV test (8.9% vs 7.1%; p < 0.001), and be diagnosed with chlamydia (6.2% vs 3.0%; p < 0.001), gonorrhoea (5.6% vs 4.6%: p < 0.001) and first-episode genital warts (1.5% vs 1.0%: p < 0.001). There was no significant difference in the proportion newly diagnosed with HIV (0.57% vs 0.69%; p = 0.268) or first-episode genital herpes (0.47% vs 0.46%; p = 0.830).

Conclusion Level 2 sexual health services play an important role in the sexual health care of MSM, especially those of younger age.

P97 MISSED OPPORTUNITIES FOR DIAGNOSING HIV IN A DISTRICT GENERAL HOSPITAL IN AN AREA OF HIGH HIV PREVALENCE

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10.1136/sextrans-2015-052126.140

Background Delayed diagnosis of HIV is associated with significantly increased morbidity and mortality. Our clinic has a high rate of advanced HIV at diagnosis (61% presenting with a CD4 <350) indicating that there may be missed opportunities for earlier testing.

Aim To review all recent new diagnoses of HIV for potential missed testing opportunities.

Methods Retrospective review of clinic, hospital and emergency department records for all new patients referred to the HIV clinic between January 2014 and January 2015. Previous hospital admissions, outpatient and emergency department attendances and GP visits were reviewed for the year up to diagnosis. Where a patient was admitted to hospital, time to diagnosis, outcome and inpatient stay was recorded.

Results 70 new patients: 24 transfers of care (excluded); 46 new diagnoses.

Gender: female	18/46 (39%)	CD4 Count	29/46 (63%) CD4 <350 11/46 (24%) CD4 <100 Mean CD4 Count 322
Sexuality: MSM	17/46 (37%)	Referral Route	SRH 13/46 (28%) Inpatient 10/46 (22%) GP 10/46 (22%) Other 13/46 (28%)
Country of birth			
UK	12/45 (27%)		
Sub-Saharan Africa	23/45 (51%)		
Other	10/45 (22%)		

24/46 (52%) were seen at least once at the hospital or by the GP in the 12 months prior to their diagnosis. 14 admissions to hospital at the time of diagnosis: mean length of stay 14 days (range 2–47).

Discussion There are significant opportunities for earlier HIV testing in our hospital and local GP practices. We are using this data as part of a business case to roll out HIV testing for all acute medical admissions.

P98 HIV TESTING IN SOUTH LONDON

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10.1136/sextrans-2015-052126.141

Background Early diagnosis is an important factor associated with HIV-related mortality, morbidity and onward transmission. The local prevalence is estimated at 7.8 per 1000 population and 61% of patients are diagnosed with a CD4 count of <350. Despite the National HIV testing guidelines being published in 2008, local HIV testing remains low due to lack of resources, funding and clinical awareness.

Objective To pilot routine HIV testing of all medical admissions during National HIV testing week.

Methods General medical admissions during 22nd–30th November 2014 were offered a third generation *INSTI* HIV point of care test (POCT) the morning after admission. A&E attendees between 9 am and 4 pm on 1st December 2014 (World AIDS day) were also offered POCTs. Basic demographics were collected and analysed with appropriate statistical tests.

Results 141 POCTs were offered in medical admissions; all 126 individuals who accepted (89%) tested negative (64 white British (51%), 10 black African (8%)). 14 refused testing; 9 tested before. 21 individuals were not offered POCTs due to unavailability/ inappropriateness. There was no statistical difference in mean ages or proportion of females/males that accepted or refused testing in this group. 32 patients tested in A&E were all negative (11 black African (34%)).

Abstract P98 Table 1 HIV testing in South London

Category	Medical	A&E	Two tailed P values *t-test, **Z-ratio
Age	56.9 (n = 126)	41.6 (n = 32)	***P < 0.0001**
Ethnicity			
Black African	n = 1	n = 11	****P < 0.0002**
White British	n = 64	n = 8	****P < 0.0089**

Discussion There was a high uptake of HIV testing amongst general medical admissions indicating routine testing is very acceptable to patients. Moreover, a younger population group presents in A&E compared to admissions; a significant proportion being Black African origin. This may be an appropriate target group to consider for testing.

P99 RENAL AND BONE SAFETY OF TENOFOVIR ALAFENAMIDE VS TENOFOVIR DISOPROXIL FUMARATE

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10.1136/sextrans-2015-052126.142

Background Off-target renal and bone side effects may occur with tenofovir disoproxil fumarate (TDF) use. Compared with TDF, tenofovir alafenamide (TAF) results in significantly reduced plasma tenofovir (TFV) and may have less renal and bone toxicity.

Methods Treatment naïve HIV-1+ adults were randomised 1:1 to a single tablet regimen of E/C/F/TAF or E/C/F/TDF once daily in two double blind studies. Assessments for all subjects included measures of glomerular and proximal renal tubular function, and bone mineral density (BMD). Four pre-specified secondary safety endpoints were tested: serum creatinine, treatment-emergent proteinuria, spine and hip BMD. Week 48 off-target side effects data are described.
Results 1,733 subjects were randomised and treated. Plasma TFV was >90% lower (mean AUC_{tau} 297 vs. 3,410 ng·hr/mL) in the E/C/F/TAF arm, compared to the E/C/F/TDF arm. Serum creatinine (mean change: +0.08 vs +0.11 mg/dL, $p < 0.001$), quantified proteinuria (UPCR, median % change; -3 vs +20, $p < 0.001$), and fractional excretion of phosphate (median % change; +0.9 vs +1.7), all favoured E/C/F/TAF. There were no cases of proximal tubulopathy in either arm. Mean% decrease in BMD was significantly less in the E/C/F/TAF arm for both lumbar spine (−1.30 vs −2.86, $p < 0.001$) and total hip (−0.66 vs −2.95, $p < 0.001$).
Conclusions Through 48 weeks, subjects receiving E/C/F/TAF had significantly better outcomes related to renal and bone health than those treated with E/C/F/TDF;. These data demonstrate important safety benefits of TAF relative to TDF, especially given the ageing of the HIV population and the need for long-term treatment.

P100 TENOFOVIR ALAFENAMIDE (TAF) IN A SINGLE TABLET REGIMEN IN INITIAL HIV-1 THERAPY

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10.1136/sextrans-2015-052126.143

Background Tenofovir alafenamide (TAF) is a novel tenofovir (TFV) prodrug that, when administered in the single tablet regimen E/C/F/TAF, has >90% lower plasma TFV levels compared to tenofovir disoproxil fumarate (TDF).
Methods Treatment naïve HIV-1+ adults were randomised 1:1 to receive a regimen of E/C/F/TAF or E/C/F/TDF in two Phase 3 double blind studies. Primary endpoint was Week 48 virologic response by FDA Snapshot algorithm in a pre-specified combined analysis.
Results 1,733 subjects were randomised and treated: 15% women, 43% non-White, 23% viral load 100,000 copies/mL. The primary objective was met, E/C/F/TAF was non-inferior to E/C/F/TDF with 92% and 90%, respectively having HIV RNA <50 copies/mL at week 48 (difference +2%, 95% CI -0.7% to +4.7%, $p = 0.13$). Virologic failure with resistance occurred in 0.8% in the E/C/F/TAF arm and 0.6% on E/C/F/TDF. Treatment related SAEs were rare: E/C/F/TAF 0.3% (n = 3), E/C/F/TDF 0.2% (n = 2). There were no reports of proximal renal tubulopathy in either arm. No single AE led to discontinuation of more than 1 subject on E/C/F/TAF. Grade 2, to 4 AEs occurring in 2% were: diarrhoea (3.3% vs. 2.5%), nausea (2.2% vs. 2.0%), headache (2.9% vs. 2.1%), and URI (3.6% vs. 3.1%) in the E/C/F/TAF vs. E/C/F/TDF arms.
Conclusions Through 48 weeks of treatment, high virologic response rates were seen in patients receiving E/C/F/TAF or E/C/F/TDF. Both regimens were well tolerated, and no unique AEs associated with TAF occurred. These data support the use of E/C/F/TAF, as a potential regimen for initial treatment of patients with HIV-1 infection.

P101 HOW SOON ARE PATIENTS TESTING OUTSIDE GUM RECEIVING A POSITIVE HIV RESULT?

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10.1136/sextrans-2015-052126.144

Introduction UK national guidelines for HIV testing 2008, recommend that any individual testing positive for HIV should see a specialist preferably within 48 h and certainly two weeks of receiving the result.
Methods All HIV positive test results performed outside the GUM clinic between January 2013 and December 2014 were obtained from the microbiology database at Frimley Park Hospital. 35 patients were identified. 20 were excluded because they were previously known to have HIV, had a "non-specific" or "weakly reactive" result.
Results Of the 15 new diagnosis, 8/15 were inpatients, 4/15 outpatients and 3/15 GP diagnosis. Two-thirds were male, 53% White British and 73% heterosexual. The average age was 46 (31–65) years. All the patients had a fourth generation HIV test and a confirmatory test. The majority (87%) were late diagnosis with symptomatic HIV/AIDS and an average CD4 count of 50 cells/mm^3. One inpatient diagnosis was missed for 5 weeks until the patient re-presented with PCP. The rest were all seen by a specialist (HIV consultant or health advisor) within 2 weeks of receiving their diagnosis with 64% seen within 24–48 h.
Discussion/conclusion The majority were late, symptomatic patients with AIDS. All but one result which was initially missed were seen by a specialist within the recommended 2 to 14 days after diagnosis. The recommendation now is that all positive results are phoned to the named consultant/GP responsible for the patient as well as the HIV/GUM team.

Category: Improving clinical practice and service delivery

P102 WHY DO PATIENTS ATTEND AS REBOOK ATTENDEES IN SEXUAL HEALTH CLINICS?

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10.1136/sextrans-2015-052126.145

Background/introduction Locally commissioners have raised concerns as regards the number of patients re-attending as a new episode of care (rebook) at the countywide sexual health clinics, rebook patients accounting for 54% of new/rebook attendances over a three month period. Commissioning concerns focussed on whether re attendance for recurrent bacterial sexually transmitted infections (STIs) due to previous suboptimal health prevention/promotion. Are there any grounds for these concerns?
Aim(s)/objectives To ascertain the reasons why patients re-attend clinics as rebook patients.
Methods A retrospective analysis of 150 case notes of rebook patients was undertaken with respect to age, gender and reasons

for attendance. In addition a questionnaire survey was administered prospectively to 172 rebook patients as regards reasons for re-attendance.
Results In the retrospective study, 106/150 (71%) were female, the average age of males was 30.4, the average age of female was 23.9. 56% (84/150) of patients attended three times or more related to genital warts, genital herpes, pelvic pain, contraception or recurrent bacterial vaginosis. In the prospective survey. 24% stated that they had re-attended because of genital warts, recurrent genital soreness or pelvic pain. 73/172(42%) were asymptomatic. Between 48–63% stated they preferred to attend because of the expertise, friendliness and confidentiality of the clinic.
Discussion/conclusion In one study, 56% of attendees had attended with recurrent issues not related to recurrent bacterial STIs. Between 48–63% had attended related to friendliness, expertise and confidentiality of the clinic inferring that quality of care and confidentiality are important factors in reasons for re-attendance.

P103 HOW AND WHY DO WE DO TESTICULAR ULTRASOUNDS? A NATIONAL CLINICAL DEVELOPMENT GROUP SURVEY OF GENITOURINARY MEDICINE CLINICS

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10.1136/sextrans-2015-052126.146

Background/introduction There is a paucity of guidelines for when testicular ultrasound (USS) should be performed and how easily GUM clinics should be able to access scans.
Aim(s)/objectives To establish what pathways are in place for USS requests and clinical prompts to order a scan.
Methods A 10 question survey was designed using Survey Monkey. This was approved by the BASHH Clinical Development Group, and disseminated within the network via the regional representatives.
Results The link was sent to 139 leads and completed by 111 clinics (79%). The majority of respondents (92.79%) had USS located in hospital. 72.97% services had no guidelines and 48.18% had no pathway for urgent scans. 77.48% requested between 1–6/ USS month. No service had to wait > 2 weeks for urgent requests, with 23.85% services having same day access. Ranking for symptoms and signs showed 62% services would often/ always scan for a mass present >14 days, and 92.79% always scan a hard, painless testicular mass.
Discussion/conclusion The majority of services have access to timely USS, although half do not have established pathways for urgent scans. The most concerning clinical features are the persistence of swelling and mass consistency, but for other features, such as pain, respondents felt that further information is required. In general, patients are relying on clinical judgment of experienced clinicians to decide the need for requesting scans. With integration of practitioners with different skills, there is need for a more standardised approach for how, when and why we perform testicular ultrasounds.

P104 PATIENT STORIES: WHAT CAN WE LEARN FROM LISTENING TO HEALTHCARE WORKERS WITH HIV

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10.1136/sextrans-2015-052126.147

Background/introduction Issues faced by healthcare-workers (HCW) with HIV are complex. HIV positive individuals continue to experience unacceptable levels of health related stigma. National HIV testing week offers a perfect platform to raise the profile of HIV within our hospital Trust.
Methods HIV positive healthcare workers were approached and asked to write an account of their experiences of testing, living and working with HIV and whether they had chosen to disclose their status to colleagues and the outcome of that experience. Key themes were extracted from the stories.
Results Six healthcare workers living with HIV, on treatment, in care, agreed to share their stories. Key themes from the stories were: missed opportunities for HIV testing pre-diagnosis, misdiagnosis and misunderstanding of HIV from HCW, feeling judged and experiencing prejudice from HCW, loss of professional confidence due to negative attitudes towards HIV/AIDS from HCW, delayed or non-disclosure of HIV status due to experiencing negative comments or behaviours towards HIV in clinical settings: however HCW who disclosed their status at work experienced significant support and empowerment, including a desire to teach and train HCW. Patient stories were used in HIV testing week to promote testing as part of a larger HIV-awareness campaign.
Discussion/conclusion Engaging HIV positive healthcare workers as part of a strategy to increase awareness of HIV in healthcare settings is empowering for patients and a powerful message to colleagues.

P105 SEXUAL HEALTHCARE PROFESSIONALS' ATTITUDES TOWARDS HPV VACCINATION FOR MEN IN THE UNITED KINGDOM

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10.1136/sextrans-2015-052126.148

Background/introduction Men who have sex with men (MSM) are at risk of HPV-associated genital warts and cancers but are unlikely to benefit from female-oriented HPV vaccination.
Aim To examine the attitudes of sexual healthcare professionals (SHCPs) towards HPV vaccination of men in the UK.
Methods An e-survey of SHCPs' views was conducted in July–August 2014. Members of UK-based professional sexual health associations were invited to participate by direct email and members' newsletters. Responses to 18 statements, with corresponding Likert scales, were used to examine their views on HPV vaccination.
Results Amongst 325 respondents (46% Doctors, 26% Nurses and 15% Health advisors), 14% are already vaccinating men against HPV and 83% would recommend gender-neutral HPV vaccination. While 64% would also recommend targeting MSM,

18% were against this strategy. Only 44% reported having sufficient knowledge about the use of HPV vaccine for MSM and 49% reported having skills to identify MSM likely to benefit from HPV vaccination. While 19% agreed that it is too late to offer HPV vaccine to sexually active MSM, 53% thought all MSM, regardless of their age, should be offered the vaccine.
Conclusion SHCPs perceived the need to vaccinate MSM against HPV. Despite insufficient knowledge, a gender-neutral HPV vaccination strategy was favoured over targeted HPV vaccination for MSM. Clear advice and guidelines for SHCPs on HPV vaccine use in men at sexual health clinics are required to ensure equitable opportunities for vaccination. If MSM-targeted HPV vaccination is recommended, SHCPs' attitudes need to be taken into account to achieve optimal uptake.

P106 HOW SHOULD PATIENTS BE CALLED FROM THE WAITING AREA WHEN ATTENDING FOR SEXUAL HEALTH SERVICES? A SERVICE EVALUATION

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10.1136/sextrans-2015-052126.149

Background/introduction The initial encounter between health professional and patient is fundamental to establishing rapport. It is important in a sexual health setting that patients feel at ease with however they are identified in the waiting area. Recent research suggested patients with HIV preferred to be identified by first name whereas most others preferred a number, and *all* patients in these categories should be called in these ways.
Aim(s)/objectives To determine the proportion of patients who expressed a preference to how they were called from the waiting room. And, to determine whether there was any association with reason for attendance, age, gender or HIV status.
Methods 167 patients who attended a drop-in clinic in October 2014 and 50 patients with HIV who had recently attended for HIV care were identified and included. Pearson's Chi-Squared Test was used to analyse the relationship between calling preference and sex, reason for attendance, and age (based on the median age of 26). When assumptions were not met, Fisher's exact test was used.
Results 60.8% (n = 132) of patients expressed no preference as to how they would like to be called from the waiting area. 36.4% requested their real details be used, 2.8% requested false details be used (n = 6). There was no statistical significance found between reason for attendance and preference (p = 0.406), age and sex did not significantly influence preference (p = 0.172, p = 0.288).
Discussion/conclusion The results suggest offering every patient the choice of how they wish to be addressed would be the most appropriate method used to call patients from the waiting area.

P107 SEXUAL HEALTH SERVICES FOR MEN WHO HAVE SEX WITH MEN (MSM): ARE THEY ACCEPTABLE?

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10.1136/sextrans-2015-052126.150

Background/introduction Locally, there is a large population of MSM. MSM have high and increasing rates of STIs and HIV: sexual health services should be accessible and MSM focussed.
Aim(s)/objectives The aims of this study were to assess patients' satisfaction with the current services, preferences on staff gender, preferences on self-taken rectal and throat swabs, and the need for a specialist MSM service.
Methods Patient satisfaction survey of MSM attending four MSM-services in our city (hospital-based STI clinic and HIV clinic, a local non-government organisation (Terence Higgins Trust) and a walk-in primary care centre). Data were analysed using SPSS.
Results 246 MSM completed surveys between January–March 2014. The median age was 35 years (18–79). Most MSM (92.3%) self-identified as gay, 7.3% as bisexual and 0.4% as other. 12.7% self-identified as HIV-positive, 61.1% HIV-negative, 20.0% unsure and 5.7% never tested. 206/246 (83.7%) did not have a staff gender preference, the male: female staff preference was 35:5/246 (14.2%:2.0%). 113/227 (49.8%) would welcome self-taken rectal/throat swabs. 101/232 (43.5%) would prefer to be seen in a specialist MSM service. Overall, there was no significant difference in preference between HIV-positive and HIV-negative/unsure/never tested. The overall satisfaction with reception staff was 95.5% (outstanding/good) and 99.1% with doctor/nurse (outstanding/good).
Discussion/conclusion Overall, there is high satisfaction with sexual health services currently provided to MSM locally. Most patients do not have a staff gender preference but almost half of MSM would prefer a specialist service. We concluded that offering self-taken rectal and throat swabs would be acceptable for many MSM patients.

P108 HOW DO MEN WHO HAVE SEX WITH MEN FARE IN INTEGRATED SEXUAL HEALTH CENTRES? AN AUDIT OF HEPATITIS B VACCINATION RATES BEFORE AND AFTER INTEGRATION

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10.1136/sextrans-2015-052126.151

Introduction In Scotland, Health Improvement Scotland (HIS) standards require that 70% of men who have sex with men (MSM) attending specialist sexual health services who are not known to already be immune should receive at least one dose of hepatitis B vaccine. The integration of sexual health services could theoretically disadvantage MSM.
Objectives Audit was performed before and after integration of genitourinary medicine (GUM) and sexual and reproductive health (SRH) services in April 2011 to assess the impact of service redesign.
Methods HBV vaccination eligibility, uptake and course completion by MSM registering as new patients in general sexual health and specialist MSM clinics was audited retrospectively for 6 month periods before and after integration of services.
Results Pre-integration 239 MSM registered for a first episode of care: 62.8% were eligible for vaccination. Post-integration 25.3% of 343 new patients were eligible. The proportion of eligible men receiving at least 1 dose of vaccination pre- and post-integration was unchanged (130/150 = 86.7% vs 78/87 = 89.7%, p = 0.6458, Chi^2 0.2223043) However, there was a significant reduction in the proportion of men receiving 3 doses of vaccination; (76/150 = 50.7% vs 30/87 = 34.5%, p = 0.0157, Chi^2 5.834).
Discussion SRH services continued to provide very high levels of initiation of HBV vaccination, even during the period

immediately after integration when clinic accommodation, pathways and staffing were in a state of change. The reduced completion rates of a 3-dose course post-integration suggest that clinic access, availability and acceptability for MSM as well as recall arrangements should be explored.

P109 "LOVE THY NEIGHBOUR": AN EVALUATION OF RELIGION AS A POTENTIAL BARRIER TO ACCESSING SEXUAL HEALTH SERVICES FOR GAY AND BISEXUAL MEN IN THE WEST OF SCOTLAND

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10.1136/sextrans-2015-052126.152

Background/introduction Outcome 5 of the Blood Bourne Virus Framework aims for a society where attitudes towards sexual health and HIV are supportive and non-stigmatising. Currently, there is no research as to whether religion is a barrier to attending sexual health services for gay and bisexual men.
Aim(s)/objectives To explore the influence of religion and its relationship to sexuality for gay and bisexual men. To explore if religious beliefs affect attendance at sexual health services and whether current standards of care at sexual health services meet their needs.
Methods Nine participants participated in semi-structured interviews; five sexual health staff; four non-NHS staff including three ordained Ministers from different religions. Questions were about their views around the influence of religious beliefs on the sexual health of gay and bisexual men in the West of Scotland.
Results Four themes were identified: barriers to attending sexual health services, influences of religion/coping behaviour, societal influences and provision of sexual health services. Seven of the nine participants identified that religion is a potential barrier to attending sexual health services. Potential conflict between faith and sexuality affect health seeking behaviour. Implications for practice included staff training, outreach work and referral to Chaplains.
Discussion/conclusion This study finds that religion is a potential barrier to attending sexual health services for gay and bisexual men, particularly if their religion and sexuality are in conflict. It can be linked to risk taking behaviour and stigma is a considerable issue. Recommendations were made for improvements in service provision. Further research is required.

P110 SELF-TAKEN SAMPLES FOR CHLAMYDIA AND GONORRHOEA IN HIV OUTPATIENTS ARE ACCEPTABLE AND PERCEIVED AS RELIABLE AND COMFORTABLE BY PATIENTS

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10.1136/sextrans-2015-052126.153

Introduction Self-taken samples increase testing for Chlamydia and Gonorrhoea in high-risk asymptomatic populations including HIV-outpatients. Women are offered self-taken vaginal samples; heterosexual men first-pass urine and MSM self-taken rectal and throat samples and first-pass urine. The acceptability of this method of testing is not well understood.
Methods An anonymous paper survey was offered to all patients attending outpatient-HIV clinic June–July 2014. Data collected: age, gender, ethnicity, sexual-orientation; perceptions of self-taken samples; whether they tested that day, and why.
Results 121 surveys were returned. Median age = 45(20–69) years; 86% male; 68% white British; 73% homosexual. 61/121 (50%) rated STI screening as 'very important', 48/121(39%) as 'worthwhile': 117/121(96%) rated offering self-taken samples in routine HIV clinic as appropriate. 86/121(71%) found the instructions 'easy' to follow and 4/121(3%) 'difficult'. 78/121 (64%) said that they thought that self-taken samples are as reliable compared to clinician-taken and 10/121(8%) thought they were more reliable. 60/121(50%) said self-taken samples were as comfortable as clinician-taken; 30/121(25%) said more comfortable. 33/121(27%) responders did self-sampling that day; 78/121 (64%) did not. Participants' reasons for accepting self-taken samples included: 'It's easier/quicker than going to a GUM clinic' (37%); 'I prefer doing the swabs myself' (25%). Reasons for not self-sampling included: 'I haven't had any sex since my last sexual health screen' (26%); 'I was not offered a STI screen today' (20%); 'I prefer to go to a GUM clinic' (16%).
Conclusions The self-swab STI screens are acceptable to patients attending HIV outpatients', and are perceived as being as reliable and as comfortable as clinician-taken samples.

P111 DISPERSAL OF A HIV COHORT FOLLOWING THE CLOSURE OF AN OUTREACH CLINIC NECESSITATED BY GOVERNMENT NHS RESTRUCTURING

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10.1136/sextrans-2015-052126.154

Introduction Coalition government health policy has necessitated NHS restructuring. Sexual health provision was opened to competitive tendering with responsibility transferring to local authorities. BASHH/BHIVA published standards and it was expected local sexual health strategy agreements would continue.
Methods DGH genitourinary care was provided by university hospital consultants since 2006 facilitated by the local sexual health network, HIV care wasn't due to funding restrictions. To improve care/retention, hub-and-spoke outreach was established in 2011 for 45 HIV+ individuals – ⅓ DGH diagnosed, ⅓ transferring from the larger centre, ⅓ from other clinics. Nine (20%) had previously disengaged. When tendering opened the local authority made no provision to maintain this service.
Results After awarding the tender to a community trust it became apparent that qualified staff would not be available to continue care of the cohort therefore it was maintained by the previous trust. Due to service fragmentation no new local referrals were made. Despite excellent feedback we reluctantly closed as continuing the spoke service became economically unviable. Patients were offered remaining with the same team at the teaching hospital (51%), transfer to another clinic locally (20%) or nationally (15.5%) with some moving overseas (4.5%). Of concern 4 (9%) are presumed to have disengaged. Several complaints were raised at local authority level.
Discussion Despite upheavals patients must remain at the centre of NHS care. We found BASHH support helpful and suggest dissemination of our experience to others. Highly regarded and well-functioning services are not immune to change and an uncertain future may be expected.

P112 HOW INTEGRATED ARE WE? A BASHH BCCG SURVEY OF GUM AND SEXUAL HEALTH CLINICS IN THE UK

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10.1136/sextrans-2015-052126.155

Introduction In 1995, the British Medical Journal published an editorial, "Rethinking sexual health clinics," which recommended integration of genitourinary medicine (GUM) and contraceptive services. In 2010, The White Paper; Healthy lives; Healthy people outlined the aim for England to work towards an integrated model of sexual health service delivery.
Objectives As current levels of service integration within the UK are unknown, this study was undertaken to assess the perceived degree of integration in sexual health services nationally.
Methods A questionnaire was distributed via the British Clinical Cooperative Group to sexual health service leads in the UK between January and June 2012. The questionnaire contained fifteen questions covering issues related to integrated sexual health service provision.
Results A total of 74 questionnaires were returned, which was a response rate of 80%. 62% saw themselves as integrated sexual health services and a further 19% had plans to integrate over the subsequent 12 months. However the location of services, service provision, structure and funding of services as well as access and staff training varied considerably between these services. For example, 78% were located within a single premise while only 52% provided combined contraception and GUM at each of their clinic sessions.
Conclusion This survey clearly shows that there is commitment towards integration but there are no defining universal standards for integrated services. We therefore recommend development of national standards defining integrated service provision and staff training.

P113 INTIMATE PARTNER VIOLENCE: USE OF EDUCATION AND CLINICAL PRO-FORMA TO INCREASE SCREENING

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10.1136/sextrans-2015-052126.156

Background/introduction Intimate partner violence (IPV) can be defined as controlling, coercive or threatening behaviour, violence or abuse between family members or intimate partners regardless of gender or sexuality. BASHH guidelines recommend that clinicians should enquire about IPV and provide support and referral to appropriate services.
Aim(s)/objectives To raise standards in screening for IPV within sexual health service and ensure appropriate support given to those affected.
Methods A retrospective audit of 200 patient records using local standards of 100% patients must be asked about IPV and of those who declared incidents must have documentation of action taken. Education was then delivered to staff and IPV added to our electronic clinical pro-forma. A re-audit was carried out alongside a survey of staff on the time taken, ease and screening phrases used.
Results In the initial then re-audit screening for IPV was undertaken in 98% then 100% of women; 61% then 99% of men; 1.9% then 2.5% disclosure; 100% then 40% documented offer of support, respectively. Following education 100% of staff felt comfortable assessing for IPV. Phrases used were variable and adapted to the patient and 80% of staff felt questioning was timely.
Discussion/conclusion IPV screening improved through the use of education and additional prompting on clinical pro-formas, particularly in male attendees. Screening for IPV was acceptable to staff and did not add significantly to consultation time. Enquiring whether any children were present in the household during IPV was not documented in any disclosed cases and ensuring patients are offered additional support needs further attention within our service.

P114 IMPLEMENTATION OF THE RCOG GUIDELINE ON EMERGENCY CONTRACEPTION ADVICE IN TWO CENTRES WITHIN LONDON

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10.1136/sextrans-2015-052126.157

Background/introduction Since 2011 guidelines by the Royal College of Obstetrics and Gynaecology (RCOG) have stated that those who provide emergency contraception are required to give certain guidance. This includes counselling on the contraception provided as well as protection against unwanted pregnancy in the future in the form of LARC (long-acting reversible contraception). This, however, is neither ubiquitously achieved or documented across the centres offering this service.
Aim(s)/objectives To ascertain the level of concordance with the RCOG guidelines at two centres within London, and highlight the importance of following and documenting them.
Methods A comprehensive search was performed using the emisweb tool in The Essex Lodge surgery in Plaistow on 11/12/14 and in the Highland Road Practice in Bromley on 15/01/15.
Results This audit collected data on 57 patients from both the practices, 20 of whom (27%) had been given no documented advice on either LARC or the medication itself, 12 (16%) contraception advice only, 25 (33%) LARC only, and only 18 (24%) advice on both.

Abstract P114 Table 1 A table outlining emergency contraception advice given at two GP surgeries in London

Advice	Number of patients
None recorded	20
Emergency contraception advice	12
LARC advice	25
Both	18

Discussion/conclusion The varying results between practices indicate that greater care needs to be taken to provide patients with information concerning both the treatment that they are requesting and preventative measures. It is also important to document that these objectives have been achieved with each consultation- something which we have found was not done ubiquitously as is recommended. We have produced an informative poster and hope that this will facilitate changes in the future.

P115 SEXUALISED DRUG USE IN PATIENTS ATTENDING AN NHS WALK-IN CENTRE

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10.1136/sextrans-2015-052126.158

Background/introduction Recent increases in reported recreational-drug use in MSM are associated with high-risk sexual behaviour and poor (sexual) health outcomes. There is little comparative research in non-MSM. Brighton Station Health Centre offers both walk-in general and sexual-health services.
Aim(s)/objectives To compare reported drug use between patients attending the sexual health and general walk-in services.
Methods A Self-completed service-evaluation recording details of drug use in the previous 6-months was offered to all patients attending during a week in October-2014.
Results 125/633(19%) completed the survey; 75/125(60%) were attending sexual-health; 33/125 identified as male and 1 as trans*. 8/33(24%) men identified as MSM. The median age was 30-years. 12/50(24%) patients attending general-health and 18 (24%) sexual-health reported drug use; most respondents using >1 drug: MDMA (n = 21) and Cocaine (n = 18) most popular. Ketamine was reported by 7/125–all heterosexual; Mephedrone, GBL and Crystal almost exclusively by MSM. 1/125 (MSM) reported Intravenous-Drug use (Crystal-Meth). Most were infrequent drug-users with 21/125(70%) using <1/month. 2/125(6%) reported using drugs >1/week. 22/30(73%) did not feel that drugs were having a negative effect on their life; 19/30 63% said that their risk behaviour and likelihood of having unprotected sex was not increased using drugs. Only 3 patients wanted advice on drug-use. Most (46%) would prefer advice about drugs from specialist drug services.
Discussion/conclusion In this small study there was no difference in reported drug use between MSM and non MSM, however the pattern of drug-use differs. As most felt that their drug-use was not problematic they are unlikely to seek advice and so general walk-in services offer opportunities for early intervention.

P116 AN AUDIT OF GONORRHOEA MANAGEMENT IN A UK SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.159

Background/introduction Gonorrhoea (GC) is a prevalent sexually-transmitted infection in the UK. The British Society for Sexual Health and HIV (BASHH) published guidelines in 2011 for the management of GC.
Aim(s)/objectives To audit the management of all patients who tested positive for GC at our centre between 1 May 2013 and 1 May 2014 against BASHH guidelines.
Methods A proforma was developed and a retrospective notes review performed for all patients who tested positive for GC from 1 May 2013 to 1 May 2014.
Results 115 patients tested positive for GC during the audit period. The prevalence of GC in this cohort was 0.9%. 46% of patients had symptom (s), 54% were truly asymptomatic, 18% of patients presented as contacts. Microscopy was performed on 80% of symptomatic patients and intracellular gram-negative diplococci were seen in 66% of these. 97% of patients were diagnosed by PCR testing and one by culture. 2 patients were diagnosed elsewhere with negative testing at our clinic. 83% had GC cultures prior to treatment. The sensitivity of culture compared to PCR testing was 59%. 93% of patients were treated as per BASHH guidelines. 65% were documented to have received written information about their diagnosis. All patients were offered test of cure, of which 61% attended within 2 weeks. 92% of patients saw health advisers for partner notification.
Discussion/conclusion Management of GC was largely in line with BASHH guidance. However, this study highlighted a need to increase written information offer and to encourage attendance for test of cure.

P117 A QUALITATIVE ASSESSMENT OF UK SEXUAL HEALTHCARE PROFESSIONALS' VIEWS ON TARGETED VACCINATION AGAINST HUMAN PAPILLOMAVIRUS (HPV) FOR MEN WHO HAVE SEX WITH MEN (MSM)

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10.1136/sextrans-2015-052126.160

Background Female-only HPV vaccination will fail to protect MSM against HPV and its sequelae i.e. genital warts and anal cancers. In the absence of gender-neutral HPV vaccination, targeted vaccination for MSM at sexual health clinics offers a valuable preventive opportunity.
Aims To identify sexual healthcare professionals' (SHCPs) perceived barriers and facilitators for MSM-targeted HPV vaccination.
Methods Nineteen telephone interviews, with UK-based self-referred SHCPs (13 doctors, 3 nurses, 3 health advisers), were conducted in October and November 2014. The interviews were recorded and transcribed verbatim. Data were analysed thematically by two researchers.
Results Nine themes were identified. The major perceived barriers were: 'concerns about vaccination programme equity and equality'; 'concerns about vaccination effectiveness'; 'challenges with targeting MSM'; 'obstacles with HPV vaccination delivery' and 'negative public reaction to targeting MSM'. The main facilitators were: 'policies and guidelines'; 'rising awareness'; 'acceptable settings' and 'adequate vaccination procedures'. While SHCPs expressed varied and sometimes contradictory views on MSM-targeted HPV vaccination, most agreed that HPV vaccination, inclusive of all school-aged boys, would be the most suitable strategy.
Conclusion Although SHCPs recognised a need to protect MSM against HPV, several challenges and obstacles associated with the introduction of MSM-targeted HPV vaccination in the UK were reported. Solutions on individual, organisational and public levels were offered. SHCPs' perspectives and concerns need to be addressed when developing policies and guidelines for a potential MSM-targeted HPV vaccination. Future research needs to examine whether negative views of SHCPs towards MSM-targeted HPV vaccination are associated with lower HPV vaccine acceptability and uptake in MSM.

P118 SHOULD WE TREAT OR RESCREEN PATIENTS FIRST WITH EQUIVOCAL CHLAMYDIA AND GONORRHOEA NAAT RESULTS?

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10.1136/sextrans-2015-052126.161

Background/introduction Equivocal NAAT results for Chlamydia and gonorrhoea (GC) cause treatment dilemmas for health professionals as there are no definitive management guidelines. Debate continues whether to rescreen and treat patients with equivocal results or rescreen the patient and await results before treatment.
Aim(s)/objectives To investigate rescreening tests for equivocal results and establish when patients should be offered treatment.
Methods A retrospective study of equivocal results from 2 GUM clinics between November 2013 and May 2014, and a third clinic between March 2010 and May 2014. HIV positive patients' results were included. Paper notes or electronic systems were examined. Data was collected using a standardised proforma and analysed using excel software.
Results 76 equivocal results (2.2% of positive results) were investigated. 62 patients (83.8%) attended recall appointments, 36 patients (58.0%) were offered treatment and rescreened, 14 (22.6%) were rescreened and awaited results prior to treatment and 2 patients (3.2%) were treated with no retest sent. 8 patients (16.1%) were treated due to a positive GC result at a second site alongside the equivocal result. Of the 54 equivocal results re-tested, 3 (5.6%) were positive and all of these resulted from equivocal GC tests (19 rescreened). All 35 rescreened equivocal Chlamydia tests were negative.
Discussion/conclusion There is currently variation in how clinicians are managing equivocal results. The findings suggest that initiating treatment for Chlamydia before rescreening may result in over treatment. GC equivocal results are more likely to be positive on re-testing, thus clinicians should have a lower threshold for treating these at the time of rescreening.

P119 THE PERFORMANCE OF NON-NAAT POINT-OF-CARE (POC) TESTS AND RAPID-NAAT TESTS FOR CHLAMYDIA AND GONORRHOEA INFECTIONS. AN ASSESSMENT OF CURRENTLY AVAILABLE ASSAYS

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10.1136/sextrans-2015-052126.162

Objectives To identify POC and rapid-NAATs for the diagnosis of chlamydia and gonorrhoea and assess their utility.
Methods Literature search for available POC and rapid-NAATs. The performance from the best-performing assays were applied hypothetically to patients in this clinic in which 100 consecutive patients with chlamydia and 100 with gonorrhoea were diagnosed in 1737 and 4575 patients respectively, with 44/100 and 54/100 treated at first attendance respectively.
Results 11 POC and 1 rapid-NAAT identified. Published performances for the best POC for chlamydia were: sensitivity 41–87%, specificity 89–99.6%. Our data suggest that if this assay were used instead of our current NAAT, for every 100 patients diagnosed currently, 23–46 extra patients would be treated at first attendance; 10–35 would go undiagnosed with 7–191 false-positives. Best chlamydia rapid-NAAT: sensitivity 97.5–98.7%, specificity 99.4–99.9%. Anticipated performance for every 100 patients diagnosed currently: 0 extra patients treated at first attendance, 1–3 undiagnosed, 0–2 false-positives. Best POC for gonorrhoea: sensitivity 54–70%, specificity 97–98%. Anticipated performance for every 100 patients diagnosed currently: 14–18 extra patients treated at first attendance, 28–32 undiagnosed, 92–137 false-positives. Best rapid-NAAT for gonorrhoea: sensitivity 96–100%, specificity 99.9–100%. Anticipated performance for every 100 patients diagnosed currently: 0 extra patients treated at first attendance, 0–4 undiagnosed, 0–5 false-positives. Rapid-NAAT would reduce time to treatment by 4 days.
Conclusion POC assays would need to be used in conjunction with a NAAT, increasing early treatment rates, expense and false-positive results. The rapid-NAAT could be used alone, with a reduction in average time-to-treat and a small reduction in sensitivity and specificity.

P120 INJECTING, OBESITY AND ANTIBIOTIC RESISTANCE: AN EXPLORATION OF NURSING PRACTICE IN RELATION TO THE ADMINISTRATION OF INTRAMUSCULAR INJECTION IN THE TREATMENT OF GONORRHOEA

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10.1136/sextrans-2015-052126.163

Background/introduction Traditionally, conventional green needles (1.5 inch) are used to reach the dorsogluteal muscle. However, in the face of increasing obesity, there may be difficulty in reaching the target muscle due to subcutaneous fat. This can lead to potential ineffective delivery of medication resulting in non-treatment of infection, and possibly contributing to antibiotic resistance.
Aim(s)/objectives To explore existing practice of sexual health practitioners in relation to site and technique when administering intramuscular gonorrhoea treatment, in NHS Greater Glasgow and Clyde.
Methods Focus group interviews with 22 sexual health participants with a variety of experiences. Interviews were analysed using a framework approach.
Results

- The dorsogluteal muscle was used for all injections excluding vaccines.
- Only two participants had heard of the recommended ventrogluteal site.
- Mentors were key influences in role modelling within clinical situations.
- No updates were reported since learning this basic skill as a student.

Despite awareness of the obesity epidemic, using a longer needle or changing target muscle site had not been contemplated until the focus group.
Discussion/conclusion Obesity constitutes health challenges to basic nursing care, and commands a practical skilled workforce in anticipation of these complexities. This study reveals a theory-practice gap in the essential assessment of appropriate target muscle, which has potential to compound resistance issues. As rapid emergence of resistant strains pose a threat to untreatable gonorrhoea, we recommend that adoption of best practice guidance is essential alongside further study to ensure efficacy of treatment.

P121 A REVIEW OF THE TELEPHONE ADVICE SERVICE FOR CENTRAL AND NORTH WEST LONDON INTEGRATED SEXUAL HEALTH SERVICES

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10.1136/sextrans-2015-052126.164

Background/introduction Although not advertised patients can phone our integrated sexual health services for advice and receive a call-back within 24 h. This service takes up significant resources without being funded.
Aim(s)/objectives Review the reasons for advice calls and establish their outcomes.
Methods A notes review was conducted of 50 calls received at each of the 3 main clinical sites in Central London over a 2 week period in July 2014. Data was collected regarding the reason for the phone call, call outcome and attendance within 6 weeks following the call.
Results The majority 129/150(86%) of calls were from existing patients. The majority of phone advice was related to contraception n = 44/160(28%), advice on sexually transmitted infections n = 22/160(14%) and patients with symptoms n = 31/160 (19%). 24/44(66%) of the contraception calls were for intrauterine device (IUD) advice (pre-and post-insertion). 50/150(33%) patients were advised to attend the clinic of whom 39/50(78%) did attend. 66/150(44%) patients were given reassurance of whom 12/66(18%) attended anyway related to their call.
Discussion The phone advice service was largely used by existing users and almost 40% attended the service after the phone call. To make more effective use of resources we have designed frequently answered questions (FAQ) page on our website to address the most commonly asked questions. Phone advice is now only available to patients on post-exposure prophylaxis (PEP) and post-procedure eg. IUD insertion.

P122 WALK-IN PRIMARY-CARE CENTRES ARE ACCEPTABLE TO MEN WHO HAVE SEX WITH MEN (MSM)

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10.1136/sextrans-2015-052126.165

Background Locally we have the highest HIV prevalence outside London and high rates of STIs in MSM. We operate a primary-care centre adjacent to a main line railway station which delivers both primary care and sexual health services. The aim of this study was to assess the acceptability of MSM in this setting.
Method Patient satisfaction survey was offered to MSM attending both services between June and October 2014.
Results 70/80(87.5%) surveys were returned. The median age of participants was 26(16–68) years. 62/70(89%) described themselves as MSM and 7/70 bisexual. 65/70(93%) attended for a sexual health screen. MSM liked the service due to ease of access (47%), proximity to work (23%) and opening-hours (23%). MSM highly rated welcome by reception staff (73% rated 5/5) and welcome by health-care-worker (HCW) (93% rated 5/5). 69/70(99%) stated they felt comfortable discussing their sexuality with the HCW. 46/70(66%) strongly agreed that the clinic environment was friendly to MSM. 29-freetext comments were received: 14/28(48%) were positive and 10/28(35%) offered service improvement suggestions: MSM suggested that streamlining appointment-booking and results via internet/mobile-phones and more evening appointments would improve the current service for them. Of concern, only 5/70(7%) of MSM attending for non-sexual health were offered STI testing.
Conclusion Our primary care centre offers a highly acceptable service for MSM. Electronic booking and results, and increased evening appointments will increase acceptability. We need to increase STI testing among MSM attending for general practice issues.

P123 ENGAGING HIGH RISK POPULATIONS IN SEXUAL WELLBEING PROGRAMMES

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10.1136/sextrans-2015-052126.166

Background/introduction Our NHS GUM/HIV clinic caters to a number of high risk populations, including transgender people, and MSM who use drugs for sex (the practice commonly known as 'ChemSex'). Simply attracting these populations to our clinics, screening and treating for infections is not providing our patients with the robust care they deserve and need; in order to have any significant impact on infection rates, we need to offer culturally competent, holistic care that addresses the broader needs of the individual. In 2014, our team established the Wellbeing programme; a series of community engagement events that addressed the sexual and general wellbeing of individuals and communities via film screenings, community discussions, performance art, poetry and open-mic events; the concept is, that if our patients experienced community cohesion, and individual sexual wellbeing, they would experience less disease, less drug/alcohol use, less stigma, and better sexual health.
Aim(s)/objectives To place sexual wellbeing at the heart of sexual health, by engaging high risk populations in community dialogues about their own sexual choices, emotional needs and general wellbeing.
Methods Open-mic events, art exhibitions, discussion evenings with porn performers and scene personalities on relevant controversial topics.
Results Successful attendances at events, winning the faith of high risk populations, engagement with our clinics.
Discussion/conclusion This oral presentation will use footage from events and an interactive discussion on how to engage local populations or engagement-resistant cohorts in treatment.

P124 WHAT IS THE ROLE OF GENERAL PRACTICE AND THE POTENTIAL BARRIERS IN PROVIDING SHARED CARE FOR PEOPLE LIVING WITH HIV: A SYSTEMATIC REVIEW

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10.1136/sextrans-2015-052126.167

Background/introduction Traditionally hospital based GUM/HIV departments have cared for people living with HIV (PLWHIV). Due to increased survival, HIV is now a chronic disease where many PLWHIV suffer from age associated illnesses. Management by generalists for such conditions is therefore essential. Shared care, however, is variably provided. We assessed the evidence on the provision and quality of shared care for PLWHIV to inform future service provision.

Aims To collate and assess the existing literature on the role of and barriers to the GP providing shared care for PLWHIV.
Methods MEDLINE, PsycINFO and EMBASE were searched using MESH terms "HIV" or "AIDS" combined with "general practice" or "primary health care". Empirical studies from developed countries relating to the role, involvement or barriers of GP utilisation in shared care were used. Eleven research articles were eligible for this review.
Results Most GPs and patients want to engage in shared care. 81–89% PLWHIV were registered with a GP and 78% had disclosed their status. Potential barriers included lack of specialist knowledge, accessibility, issues of confidentiality and stigmatisation, and poor communication between services. GP engagement was dependent on their experience with HIV, local prevalence of HIV and patient level of morbidity.
Conclusions This review demonstrated large variations between UK health service provisions for PLWHIV. Disclosure to GPs has improved in the post-HAART (highly active antiretrovirals) era; however remaining barriers to shared care, primarily communication between services, needs to be addressed. Further research to develop models of shared care for PLWHIV is necessary to provide comprehensive safe, good quality care.

P125 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEAE

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10.1136/sextrans-2015-052126.168

Background This was a retrospective analysis of clinic performance in the 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 2014 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared to data collected at the same clinic for the same six months in 2007 to 2014. The total number of cases identified in 2014 was 126.
Results

Conclusions Current BASHH targets have been achieved in only 1 out of 5 criteria, there was a drop from 100% (2013) to 97% (2014) in patients not receiving 1st line treatment. Targets for chlamydia screening/treatment were met. There was very poor performance in offering written advice in 2014 – this is likely due to poor documentation rather than clinical practice. A new facility, implemented during the audit period, on our computer system now gives a visual prompt for recording the provision of written information. This will need to be re-audited in 2015 to look for improvement. We recommend making the input of information to be a compulsory entry before allowing the entry to be saved. Further staff training and awareness of arranging TOC needs to be addressed, and we recommend a re-audit of this next year. We suggest that we should implement a TOC entry facility on our patient record to prompt users to arrange this for the patient.

P126 THE 2014/15 EUROPEAN COLLABORATIVE CLINICAL GROUP (ECCG) SERVICE EVALUATION ON THE MANAGEMENT OF PELVIC INFLAMMATORY DISEASE

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10.1136/sextrans-2015-052126.169

Background Pelvic Inflammatory Disease (PID) describes a broad spectrum of disease primarily diagnosed clinically, with signs and symptoms lacking both specificity and sensitivity. Mycoplasma genitalium (MG) is being increasingly implicated in cases of non-chlamydial non-gonococcal PID. The core principle of the management of PID remains to maintain a low threshold for diagnosis and treatment to prevent long-term sequelae.
Aim To evaluate the current management of PID amongst sexual health physicians across Europe against the current European guidelines.
Methods A clinical scenario based questionnaire was developed by a panel of European experts on PID, and this was disseminated to a group of 120 sexual health physicians across 38 countries who are members of the European Collaborative Clinical Group (ECCG) – a network of sexual health specialists who conduct questionnaire based research across the European region.
Results Provisional results demonstrate variation in practice across Europe and this is most marked in routine testing for and treatment of MG-associated PID, factors influencing the choice of antibiotic therapy, and action taken when an intrauterine device or system is *in situ*. Full results will be available by the conference.
Conclusion The management of PID varies across Europe and is not always in line with current European guidelines. There is a need for ongoing Europe wide education to ensure that patients are receiving evidence based care. Furthermore, there are issues

Criterion	2007	2008	2009	2011	2012	2013	2014
1) All patients treated for GC should be recommended to have a test of cure (TOC)				(36% had a TOC)	91% (66% had a TOC)	84.6% (52.9% had a TOC)	91% (60% had a TOC)
2) All patients with gonorrhoea should be screened for genital infection with *Chlamydia trachomatis* or receive presumptive treatment for this infection	100%	100%	100%	98.6%	100%	100%	100%
3) All patients identified with gonorrhoea should have partner notification carried out according to the published standards of the BASHH Clinical Standards Unit	82%	95%	92%	92%	88%	90.4%	93%
4) All patients identified with gonorrhoea should be offered written advice about STIs and their prevention	32%	64%	81%	61%	50%	66%	27%
5) All patients with gonorrhoea should receive first-line treatment, or the reasons for not doing so should be documented	77%	96%	100%	97%	88%	100%	97%

in clinical practice which are currently not covered by the European guidelines and these need to be reviewed to provide physicians with appropriate guidance.

P127 SPECIAL INTEREST CLINIC: A NOVEL GENITOURINARY MEDICINE SERVICE INITIATIVE PROVIDING CONTINUITY OF CARE AND EDUCATIONAL OPPORTUNITIES

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10.1136/sextrans-2015-052126.170

Introduction External referral to dermatology and psychosexual services from genitourinary medicine (GUM) can cause delays in patient care. To counter this within our service an experienced consultant has established a Special Interest Clinic (SIC) reviewing dermatology, erectile dysfunction and complex GUM cases. Written educational feedback is offered to internal referrers. We reviewed the impact of SIC.
Aims To evaluate the service offered by SIC.
Methods Data was collated from randomly selected patient records who attended SIC between April 2012 and April 2013.
Results A total of 100 records were reviewed. 67 patients were male, 25 of whom were MSM. Patients were ethnically diverse, White British (52) being the most common ethnicity. Median age was 33 years (range 19–70). 12 patients were HIV-infected. Internal referrals predominated (96) and average waiting time from referral was 6.2 weeks (range 0.14–28). Broadly stratifying referrals 40 patients were complex GUM, 35 psychosexual medicine, 25 dermatology. The most prevalent diagnoses were erectile dysfunction (23) and lichen sclerosus (9). 9 patients required skin biopsy, 8 of which were performed within SIC. Ongoing follow up was recommended to 60 patients, of which 43 (71.7%) were retained. 27 patients were discharged after first attendance. 77 referrers requested feedback, all received it.
Conclusion Keeping patients within our service provided continuity of care. The availability of formal feedback increases educational opportunities for referrers. We recommend experienced clinicians consider establishing similar SICs in other services. A challenge services will encounter is the lack of specific SHHAPT coding for prevalent SIC diagnoses.

P128 MEETING STANDARDS IN MANAGEMENT OF SEXUAL ASSAULT: ARE WE THERE YET?

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10.1136/sextrans-2015-052126.171

Background/introduction Effective management of victims of sexual assault is important to encourage people to report abuse and receive care. BASHH provide guidance on management of sexually assaulted patients. We reviewed case notes of 36 patients who were treated for sexual assault.
Aim(s)/objectives

- To identify demographic characteristics of sexually assaulted victims attending the clinic.
- To understand how we meet the BASHH guidance (2011) in the management of sexual assaults.
- To assess the usefulness of locally used template for cases of sexual assault

Methods Case notes of 36 patients treated for sexual assault who attended the clinic from January 2013 to March 2014 were reviewed. A questionnaire was designed to collect data and the data was analysed using Microsoft excel.
Results 44 case notes were identified but 36 cases fulfilled the inclusion criteria. Of the 14 auditable outcomes, only documentation of essential criteria (standard 1) reached the 100% standard and six achieved above 75% of the expected standard of 100%. These include documentation of physical injuries, self-harm risk assessment, offer of emergency contraception, offer of active vaccination against Hepatitis B and assessment of child protection need. Offer of baseline STI screening was documented in 72%. Poor documentation of BASHH criteria on further referral for physical injuries (33%) and repeat testing for STIs (36%) were identified.
Discussion/conclusion Importance of complete documentation on sexual assault cases should be emphasised. Reviewing the sexual assault template to capture all necessary information was identified as a result of this audit.

P129 SHARED CLINICAL PRIORITIES IN AN INTEGRATED SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.172

Background/introduction Demand exceeds capacity in many sexual health services. In response to this, our GUM department developed a triage policy based on agreed clinical priorities. When we integrated with the local Sexual and Reproductive Health (SRH) service, which had its own more loosely defined priorities, an essential part of the process was to agree shared clinical priorities.
Aim(s)/objectives To create a single, agreed set of priorities across an integrated sexual health service.
Methods We reviewed the existing GUM priorities, and agreed they were still applicable. We created a formal set of SRH priorities. We merged the two into an integrated set of clinical priorities that would apply across the whole service.
Results The existing GUM priorities were patients with or at significant risk of HIV, followed by patients with or at significant risk of syphilis, then gonorrhoea¸ then chlamydia. The SRH priorities were widespread provision of long-acting reversible contraception (LARC), followed by emergency contraception (especially IUD), high quality abortion service, services for young people and services in more deprived areas. The single, agreed set of priorities for the integrated service were HIV-positive patients, women with unplanned pregnancy and under 16's; followed by patients at high risk of HIV, high risk of unplanned pregnancy, and/or people living in areas of high deprivation.
Discussion/conclusion Creating shared priorities has proved invaluable when pressure on the service builds up. Both services had to shed priorities that might have hitherto been regarded as "sacrosanct".

P130 DOES USE OF A PRO FORMA IMPROVE MANAGEMENT OF COMPLAINANTS OF SEXUAL ASSAULT?

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10.1136/sextrans-2015-052126.173

Background/introduction A large GUM clinic introduced a sexual assault pro forma to improve the management of patients alleging sexual assault.
Aim(s)/objectives To compare standard of care of complainants of sexual assault with and without use of pro forma.
Methods A retrospective review of patient records with evidence of first disclosure of sexual assault was undertaken for an eight month period. Data on 16 outcomes including 14 nationally auditable standards was analysed against use of the pro forma. Data analysis was performed using Stata. Data collection will be extended to twelve months.
Results 65 patients were included. A pro forma was only completed in 58%. The following outcomes were significantly associated with pro forma use: HIV risk assessment (p = <0.001), detailed history of assault (p = <0.001), offer of hepatitis B vaccine (p = 0.03) and completion of self-harm assessment (p = <0.001). Other outcomes supporting pro forma use were risk assessment of vulnerability (p = <0.001) and offer of psychological support (p = <0.001). STI testing specifically for hepatitis C and *trichomonas vaginalis* was below the national auditable standard in both groups.
Discussion/conclusion The use of a pro forma has improved clinical care of complainants of sexual assault. Poor uptake of use of the pro forma within the clinic needs to be addressed. Amendments to the pro forma may improve outcomes such as increasing offer of testing for hepatitis C and *trichomonas vaginalis*.

P131 MANAGEMENT OF SEXUAL ASSAULT IN A COUNTY-WIDE INTEGRATED SEXUAL HEALTH SERVICE: INFREQUENTLY REPORTED BUT COMPLEX NEEDS IDENTIFIED

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10.1136/sextrans-2015-052126.174

Background/introduction County Durham and Darlington NHS Foundation Trust (CDDFT) recently published local standards of care for patients disclosing sexual assault within the sexual health service. CDDFT is the sole provider of sexual health services throughout the county, offering fully integrated GUM, Family Planning and HIV clinics.
Aim(s)/objectives This study aims describe the current management of sexual assault within CDDFT Sexual Health Services.
Methods Patients who disclosed an alleged sexual assault from 01.01.2014–31.12.2014 were identified by local electronic codes and retrospective case note review was performed. Summary statistics were calculated using STATA v 11.0 and means /percentages presented as appropriate.
Results Of 55 patients reporting alleged sexual assault, 44 case notes were available for review (80%). 39 patients were female (89%) and 5 were male (11%) with a similar mean age of 24.5 years. Police involvement was equally prevalent in patients reporting recent verses historical sexual assault (18/28 (64%) v 9/16 (56%) p = 0.52) and incident details were recorded in all cases where police referral was declined (17/17, 100%). 39/44 patients accepted STI screening, 7/44 patients were at risk of unwanted pregnancy and accepted emergency contraception; 12/44 patients were offered prophylactic antibiotics and 24/44 were offered Hep B vaccination; 6/44 patients commenced PEP and 6/8 under 18 year olds were referred to local safeguarding teams.
Discussion/conclusion Patients reporting alleged sexual assault were seen infrequently but often had complex needs. Implementing new local policy with strengthen our ability to identify these patients and standardise our approach to management.

P132 "WHAT DO I DO WITH MY VIBRATOR DOCTOR?"

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10.1136/sextrans-2015-052126.175

Background/introduction The use of sex toys is common amongst same sex relations and heterosexuals. Evidence exists that sex toys can be a method of transmission for many sexually transmitted infections (STI). Literature from BASHH and FSRH are explicit in recognising this and it is therefore important that we discuss the importance of safe sex toy use with our patients.
Aim(s)/objectives Our aims were to assess whether clinicians routinely discussed the use of sex toys; if so with whom and whether advice was routinely given post diagnosis of an STI.
Methods A survey was designed and sent to local sexual health clinics. Responses were anonymous, using a web site link. Respondents were asked, amongst other questions, if they routinely discussed sex toy usage with their patients and if so when and with whom; and what advice was given regarding sex toy usage post diagnosis of an STI.
Results Responses were received mostly from consultants and specialist nurses. 25% regularly discussed sex toys largely during safe sex discussions. Respondents felt women who have sex with women and men who have sex with men (94%, 84% respectively) benefitted most from this discussion. 22% discussed possible STI transmission with sex toys; however 88% did not routinely give advice post STI diagnosis.
Discussion/conclusion Results show that despite evidence there is limited discussion regarding safe sex with sex toys in this group of clinicians. This could lead to unawareness amongst our patient population and unnecessary transmission of infection. To improve this, education is to be undertaken via our regional BASHH meeting.

P133 THE EFFECT OF INTRODUCING ROUTINE SELF-TAKEN EXTRA-GENITAL SWABS IN A GUM CLINIC COHORT

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10.1136/sextrans-2015-052126.176

Background Starting July 2013, self-taken extra-genital swabs were offered routinely to all patients attending the department.
Aim To assess detection of extra-genital infection since introduction of self-taken swabs.
Methods We compared patients diagnosed with Chlamydia and Gonorrhoea in the 6-month period before (February–July 2012) and after (February–July 2014) the introduction of self-taken extra-genital swabs. The rate of self-swabbing was determined in separate consecutive groups of 100 patients who had extra-genital swabs in the same periods.

Results There were 408 (98 Gonorrhoea, 310 Chlamydia) detected infections in the 2012 period and 404 (121 Gonorrhoea, 283 Chlamydia) in 2014. Between 2012 and 2014, the rate of detected extra-genital Chlamydia/Gonorrhoea infections increased 4-fold from 18/408, 4.4% to 77/404 19% ($P < 0.0001$). The rise was seen in both pharyngeal (10/408, 2.45% vs 48/404, 11.8% $P < 0.0001$) and rectal infections (8/408, 2% vs 40/404, 9.9%, $P < 0.0001$). Significant rises were seen in MSM in rectal (5/408, 1.2% vs 28/404, 6.9% $P < 0.0001$) and pharyngeal infection (10/408, 2.5% vs 21/404, 5.2%, $P = 0.02$) and for women in rectal (3/408, 0.7% vs 12/404, 3% $P < 0.02$) and pharyngeal infection (0/408, 0% vs 20/404, 5%, $P < 0.0001$). In these patients, rates of extra-genital self-swabbing rose from 0% (0/24) to 58.5% (141/241), $P < 0.0001$. In separate samples of consecutive un-infected patients having extra-genital swabs, self-swabbing rose from 0% (0/100) to 90% (90/100) $P < 0.0001$.
Conclusion The introduction of routine self -taken extra-genital swabs has led to a large rise in detected extra-genital Chlamydia and/or Gonorrhoea infection, especially for MSM and women. The rise in rates of extra-genital self-swabbing shows that this is acceptable and effective.

P134 CHAPERONES FOR INTIMATE EXAMINATIONS IN A GENITOURINARY MEDICINE CLINIC: AUDIT OF DOCUMENTATION

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10.1136/sextrans-2015-052126.177

Introduction BASHH, GMC, RCP and FSRH provide guidance stating that a chaperone should be offered for intimate examinations and the name of the chaperone should be documented. Record keeping is often found to be suboptimal in litigation. Our proformas have prompts for both offer and name of chaperone.
Aim/objectives To audit our documentation of chaperone offer (including name) for intimate examinations.
Methods 20% case notes for new episodes seen by doctors May–July 2014 were randomly selected and reviewed. Gender of doctor and patient were recorded.
Results 208 case notes were examined. 114 patients were examined (61 not examined; 33 inadequate documentation). 96/114 (84.2%) had the offer of a chaperone documented; 18 (15.8%) did not. Of the 96 where the chaperone was documented as offered, 89 (93%) had the chaperone's name documented; 7 (7%) did not. In 64 cases, doctor and patient were the same gender, and in 50 cases they were opposite gender – chaperone offer was documented in 87.5% and 80% respectively ($p = 0.278$, student's 2 tailed t-test).
Discussion Chaperones for intimate examinations reassure and protect both doctors and patients. With the GMC dealing with just under 30 allegations in 2014 recording of this is potentially pivotal. Despite prompts, only 78% had both offer and name documented. It was concerning that in 33 cases it was not clear as to whether or not an examination had occurred. The results ran counter to expectations with offer of a chaperone higher when patient and doctor were the same gender although this was non-significant.

P135 A MULTI-DISCIPLINARY APPROACH TO FGM REPORTING AND SAFEGUARDING ASSESSMENTS IN THE GUM CLINIC

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10.1136/sextrans-2015-052126.178

Background/introduction Around 103,000 women aged 15–49 in England and Wales are living with the consequences of female genital mutilation (FGM), which has no clinical benefits and is illegal in the UK. Despite this, girls in some communities in the UK continue to have this procedure performed. Mandatory national reporting of FGM cases was introduced in September 2014 and support and safeguarding assessments are required.
Aim(s)/objectives To produce a clinic policy for appropriate assessment of women with FGM.
Methods GUM clinic staff worked with our trust FGM lead, local social services, community paediatric colleagues and support organisations to develop a policy for women with FGM. This incorporates both the mandatory reporting and safeguarding assessment.
Results A clinic proforma for assessing women with FGM was developed to enable clinic staff to follow the new policy. This was introduced following training in November 2014 and we have piloted it since then. To date this has been used to assess 6 women who had undergone FGM; all were black African and one was unaware that she had "been cut". Three women had had type 3 FGM performed, two type 2 and one type 1. Four women reported symptoms as a result of FGM and five stated that they were "against" the procedure. No safeguarding issues were identified.
Discussion/conclusion Whilst implementing the mandatory reporting required for women who have been subjected to FGM, we have successfully developed and implemented a new policy to ensure that appropriate safeguarding assessments are made within the clinic.

P136 SERVICE EVALUATION OF CARE NEEDS OF YOUNG PEOPLE AGED UNDER 25 LIVING WITH HIV: ARE THEY CONSISTENT?

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10.1136/sextrans-2015-052126.179

Background/introduction CHIVA standards recommend all adolescents and young people living with HIV have an individualised care plan to transition them to adult services over time, as is appropriate to their age, developmental stage and social circumstances. Within the UK, adolescents living with HIV acquire the infection either via vertical transmission or sexual acquisition. These 2 groups differ in terms of medical, social and psychological needs, with the former group historically doing less well in terms of adherence and prognosis compared to the latter group.
Aim(s)/objectives To understand and characterise patients under the age of 25 attending for HIV care in a provincial UK adult HIV clinic, and identify care needs.
Methods Case note review of all HIV positive patients attending care under the age of 25.

Results Of 39 patients (29 male, 10 female), mode of transmission was 27(69%) sexual, 11(28%) vertical, and 1 unknown. The vertically-acquired cohort have lower CD4 counts (64% vs 93% CD4 >350), more resistance mutations (including triple class resistance) and lower rates of viral suppression (45% vs 90%) compared to the sexually-acquired cohort. Retention in care is also lower, (72% vs 92% attending in the last year). STI rates are high overall but higher in the sexual transmission cohort, 75% vs 55%.
Discussion/conclusion The under 25 HIV clinic cohort comprises 2 distinct groups: a vertically -acquired cohort with poorer outcomes, who consistently require more support and motivation to remain engaged in care; and a sexually-acquired cohort who adhere to HAART, but have higher rates of STIs and would benefit from support involving motivational interviewing and health promotion.

P137 TACKLING HIV RELATED STIGMA AND DISCRIMINATION WITHIN NHSGGC SERVICES

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10.1136/sextrans-2015-052126.180

Background/introduction Individuals with HIV report experiencing stigma and discrimination. Outcome 5 of the Scottish Government Sexual Health and BBV Strategy (2011–15) aims to address this issue. Locally a system was established to record and collate events on a 'third party' basis, which revealed that most incidents occurred within NHS services.
Aim(s)/objectives In collaboration with the HIV Patient Forum, we examined HIV stigma among NHSGGC staff by:

- Assessing knowledge of HIV
- Measuring HIV attitudes and beliefs
- Capturing staff experiences of HIV stigma

Based on the findings, we are developing an appropriate staff CPD programme.
Methods Between 8–23 July 2013, an anonymous self-complete questionnaire was sent to all 38,000 NHSGGC employees. This was circulated by email from the Director of Public Health with reminders issued via internal staff bulletins.
Results A 10% completion rate was achieved (n = 3,971 responses). Staff

- had variable knowledge of HIV which was much poorer in relation to treatment advances and routes of transmission.
- held mixed attitudes with less favourable attitudes correlated to poor knowledge
- reported practice which could be perceived as discriminating against patients
- expressed a strong desire for greater knowledge and access to training

Discussion/conclusion This survey from the largest UK NHS employer provides evidence that poor knowledge and attitudes are based on outdated information and assumptions which in turn leads to poor patient experiences. This has provided a platform to develop pro-active anti-stigma approaches ranging from a staff-facing campaign, refreshed HIV training and development of a patient empowerment toolkit.

P138 CASH DIRECT: INCREASING PATIENT CHOICE AND ACCESS TO LARC

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10.1136/sextrans-2015-052126.181

Background/introduction Busy lifestyles and women's continued need and desire for reliable methods of contraception, has led to the development of 'CaSH Direct' which offers LARC assessments and procedures at times that are convenient to women but without the need for multiple visits to.
Aim(s)/objectives CaSH Direct aims to:

- Increase women's access to LARC
- Reduce demand on clinics
- Increase women's choices of times and location of procedure
- Reduce the time women spend in clinic
- Make more efficient use of staff time

Methods Women attending clinic and requesting a LARC are offered a telephone consultation at a time that is convenient to them (day or evening) meaning women do not need to take time away from work or family to access the service avoiding the need to wait in clinic to be assessed. Clients are then contacted by a sexual health practitioner who completes an assessment over the phone allowing the woman to take the call in an environment that is familiar to her and without the cost or time implication of attending clinic. A suitable appointment time is made at the end of the assessment for the client to attend an agreed clinic for the procedure to be carried out.
Results Client feedback has proved to be favourable for the service with 70% rating the service as excellent, pressure in walk-in clinics has been eased and appointment times are being utilised more effectively.
Discussion/conclusion CaSH Direct has made a positive impact on service provision and client choice through innovative and effective use of skills within the service.

P139 TO ATTEND OR NOT TO ATTEND – "WHY" IS THE QUESTION?

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10.1136/sextrans-2015-052126.182

Background/introduction Documents such as "10 high impact changes for genitourinary medicine 48 h access" produced by the Department of Health (DH) in 2006 have helped reduce waiting times and increase capacity. Our service experienced a significant increase in the rate of non-attendance of appointments following a change in service base in February 2014. In response we decided to ascertain whether adopting some or all of the DH's high impact changes would improve the poor attendance.
Aim(s)/objectives On review we were already employing most of the recommended changes. One omission was high impact change 5: "Review current access system and make it easier for patients to access the service", therefore we asked patients their preferred means of attendance (appointment or drop in) and times of attendance.
Methods 105 services users were questioned over a 4 week period from the 1st until the 31st August 2014.

Results 44% preferred the option of both appointments and drop in, whilst 28% each favoured either all appointments or drop in access only. There was no preferred time of attendance.
Discussion/conclusion As the service already provides both appointments and drop in access the audit provided little to no evidence that a change to service delivery would reduce levels of non-attendance. There remains minimal data about how best to fulfil public and individual sexual health obligations, especially to an extensive rural community such as ours. A further audit on actual non-attenders could identify patterns in patient expectation.

P140 MISSED OPPORTUNITIES FOR ENSURING ADEQUATE CONTRACEPTION: LESSONS FROM A RURAL SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.183

Background/introduction Our county-wide service is undergoing increasing integration which makes public health sense. Ideally, risk of both sexually transmitted infections and pregnancy should be addressed with patients.
Aim(s)/objectives We looked at missed opportunities for ensuring adequate contraception during routine GU appointments.
Methods A retrospective notes review of 50 consecutive new female attendances over 2/12 was conducted, with a follow up at 4/12 to check contraception initiation or pregnancy.
Results Consultations were conducted by 16 different staff, 44%(7) of whom are trained to initiate oral contraceptive pills (OCPs), 4 fit implants and 2 fit IUCD/IUS. 23 and 27 patients were seen by nurses and doctors respectively. Contraception methods, including none, were universally documented. 22(44%) patients were using long acting reversible methods of contraception (LARC) and 28%(14) an OCP. Pill compliance was documented in 5(36%) and advice given in 1 case. Only 4 (14%) of the 28 non –LARC patients had LARC discussion. 7 patients used condoms and 7 no contraception. 5(36%) of these were advised to book a contraception clinic (CC)/GP appointment for contraception, 2 of whom failed to attend a subsequent CC. 1 patient was quick- started on an OCP. 2 patients were known to have conceived during the subsequent 4/12; 1 had LARC and 1 OCP at initial visit. 6(12%) and 1 patient/s were deemed at risk of pregnancy and appropriately provided with emergency contraception respectively.
Discussion/conclusion There were missed opportunities to maximise contraception efficacy. Time restrictions and lack of staff training pose barriers which we need to address.

P141 HOW ACCURATE IS CLINICAL CODING IN RECENTLY INTEGRATED SEXUAL HEALTH SERVICES?

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10.1136/sextrans-2015-052126.184

Background/introduction Clinical coding in England provides monitoring data for Public Health England via the Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and Sexual and Reproductive Health Activity (SRHAD) returns. In London, this data is also used to reflect activity for the Integrated Sexual Health Tariff (ISHT) which may form the basis for payment in future. Integration of contraception and GUM services presents a challenge in maintaining accuracy of clinical coding.
Aim(s)/objectives To audit the accuracy of SHAPPT, SRHAD and SRH coding in a multi-site integrated sexual health service, comparing sites traditionally providing GUM services vs contraception.
Methods Local standards were agreed; 95% of patients should have accurate SHAPPT, SRHAD and SRH codes. 229 records from 2 GUM sites and 53 from 1 contraception site were audited from attendances between May and July 2014.
Results

	Traditional GUM (% correct)	Traditional contraception (% correct)
"T" codes	140/142 (99%)	22/25 (88%)
P1A, P1B, P1C codes	209/229 (91%)	7/34 (21%)
A-C codes	58/67 (86.5%)	3/11 (27%)
SRHAD	31/46 (67%)	29/31 (94%)
SRH	2/20 (10%)	5/9 (55%)

Discussion/conclusion As expected, the accuracy of coding reflected the traditional nature of the sites. The locally set standard of 95% was only reached on one occasion. Missing SRH codes alone would equate to lost income of £1259 from 77 visits if the ISHT was in place. Staff training and weekly capture and correction of missing HIV codes through targeted email reminders has resulted in an improvement in coding.

P142 USING THE "SPOTTING THE SIGNS" PROFORMA IN A GUM CLINIC TO FACILITATE IDENTIFICATION OF CHILD SAFEGUARDING CONCERNS

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10.1136/sextrans-2015-052126.185

Background/introduction In the wake of recent events regarding child sexual exploitation, BASHH produced the 'Spotting the Signs' guidance. Our GUM department has been using the 'Spotting the Signs' proforma since August 2014 for all under 16 year olds routinely and any patients aged 16–17 where concerns identified.
Aim(s)/objectives The aim of this project was to review the data gathered using the proforma and review the number of safeguarding referrals made.
Methods All under 16s and any patients aged 16–17 seen between August and December 2014 were identified. A retrospective case note review was undertaken of all the proformas. Data gathered included non-consensual sex, age differences, drug and alcohol issues, coercion and number of referrals to child safeguarding.
Results 20 patients were identified (16 female, 4 male); 18 cases were under 16 years. Two patients aged 16–17 had been assessed using the proforma. 50% of patients were identified as having mental health issues, 55% were identified with concerns regarding exploitation and 20% were noted to have problematic drug/alcohol use. 55% of patients were referred to safeguarding services.

Discussion/conclusion Use of the proforma has increased identification of mental health issues, highlighted concerns regarding age differences and provided details of drug/alcohol use, social circumstances and sexual exploitation. The data suggests that use of the proforma allows a more detailed risk assessment thereby increasing the likelihood of identifying safeguarding issues. We initially used the proforma routinely in all under 16 year olds and have since expanded this to all under 18 year olds.

P143 IMPLEMENTATION OF AN ASYMPTOMATIC PATHWAY SIGNIFICANTLY REDUCES CLINIC VISIT DURATION

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10.1136/sextrans-2015-052126.186

Background/introduction Our sexual health clinic in a busy city-centre is experiencing increasing patient demand. The challenge is to provide time-efficient, quality patient-care. Developing a structured screening pathway for asymptomatic patients to be seen by nursing assistants (NAs) could reduce time spent within clinic.

Aim(s)/objectives

1. To successfully and safely introduce a pathway enabling NAs to screen asymptomatic, heterosexual patients.
2. To assess the pathway's impact on patient-care including:
   - Time spent within clinic
   - Screening tests offered/accepted (following BASHH guidance)

Methods

- Baseline data was recorded for two weeks prior to pathway introduction.
- The asymptomatic pathway was implemented, including self-completed symptom questionnaire and patient assessment/testing tool.
- A competency package for NAs was introduced.
- Comparison of patient-care to baseline was made.

Results Eighty asymptomatic patients were identified during the initial two-week period. Following introduction, thirty-three patients followed the pathway. Four subsequently disclosed symptoms and were excluded.

Abstract P143 Table 1 Asymptomatic pathway

	Pre Asymptomatic Pathway (80 patients)	Post Asymptomatic Pathway (29 patients)	p Value
Mean Time in clinic (minutes)	67	44	0.00001
HIV Testing Offered	79 (98.7%)	29 (100%)	0.55
HIV Testing Accepted	66 (83.5%)	25 (86%)	0.65
Chlamydia positive NAATs	2 (2.5%)	0 (0%)	0.39

Discussion/conclusion Early results show significant reductions in clinic visit duration. This improves patient experience, increases patient numbers and allows trained staff to manage complex patients. HIV test offer and uptake increased. More data are needed for future analyses. NAs will continue to be supported in pathway provision. Further elements will be introduced to assess and manage risk-taking behaviour.

P144 VALIDATION OF THE DENVER HIV RISK SCORE FOR TARGETING HIV SCREENING IN VANCOUVER, BRITISH COLUMBIA

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10.1136/sextrans-2015-052126.187

Background/introduction The Denver HIV risk score (DHRS) is a prediction rule developed for targeting HIV testing and validated in U.S. clinical settings (PMID: 22431561). The final model of the DHRS included age, gender, race/ethnicity, sex with a male, vaginal intercourse, receptive anal intercourse, injection drug use, and past HIV testing.

Aim(s)/objectives We aimed to validate the DHRS in patients attending two publicly funded STI clinics in Vancouver, British Columbia.

Methods We validated the model using electronic records (2000–2012) from 47,175 clinic visits. Each visit was scored based on variables included in the DHRS. Visits were stratified into 5 risk groups according to their score: very low (<20), low (20–29), moderate (30–39), high (40–49), and very high (50). The model's discrimination and calibration for predicting an HIV diagnosis were examined by AUC and the Hosmer-Lemeshow (H-L) statistic. We examined the sensitivity and proportion of patients that would need to be screened at different cutoffs of the risk score.

Results The prevalence of HIV infection was 0.46%. Validation demonstrated good performance: the AUC was 0.80 (95% CI: 0.79–0.81) and the H-L ^{2} = 8.8, 8 df, $p = 0.36$. HIV prevalence within each risk groups was: 0%, 0.05%, 0.25%, 0.86%, and 1.23%, respectively. HIV testing is recommended for scores of 40. The DHRS identified cases with a sensitivity of 96% and a fraction screened of 41%.

Discussion/conclusion The DHRS performed well in these STI clinic settings in Vancouver, accurately identifying individuals at increased HIV risk, and may be useful for providing individualised estimates of risk as part of routine HIV screening.

P145 INTRODUCTION AND TRIAL OF A "CHEMSEX" SUPPORT SERVICE IN A SOUTH WEST LONDON GU CLINIC

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10.1136/sextrans-2015-052126.188

Background/introduction Since 2013 our centre has recognised a problem of recreational use drug associated with sex amongst MSM.

Aim(s)/objectives A joint survey with the local commissioners was set up to establish the extent of the problem in the borough and to identify a need for further services.

Methods 100 HIV negative MSM and 50 HIV positive MSM completed a patient survey with questions regarding recreational drug use related to "chemsex".

Results Results indicated a high level of drug use with 60% (90/150) reporting any drug use and 21% (32/150) specifically using party drugs in the last 6 months. Clients were asked where they would like to have a specialist drug service and the

majority preferred the sexual health clinic as an acceptable venue 37% (56/150). A weekly "in-reach" service was set up with the local Drug Service to run alongside the MSM evening clinic. From August to December 2014, there were 15 clinics in total with 21 visits (max capacity 30 visits). 25% of those seen were from the local borough; the rest of the clients were from neighbouring boroughs.
Discussion/conclusion The service to date has been a clinical and operational success. A patient satisfaction questionnaire completed by 13 clients noted 92% were happy to be seen at this venue, 85% felt the provision of this service was worthwhile and 85% would recommend this service to others. Further work in this area with a targeted MSM history proforma, chemsex leaflet and needle exchange schemes are also being developed.

P146 ESTABLISHING A SEXUAL HEALTH RESEARCH PRACTICE NETWORK IN THE NORTH EAST

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10.1136/sextrans-2015-052126.189

Background/introduction There is a strong tradition of collaborative research and practice in sexual health in the North East of England.
Aim(s)/objectives The North East Sexual Health Research Practice Network brings together colleagues from academia, public health and clinical practice to share research findings and identify research questions based on local issues.
Methods A project group with representatives from local universities, Public Health England and local authorities developed a proposal for a regional sexual health research network to promote collaboration and share evidence of what works. A steering group was established to develop an initial work plan for the network.
Results The network has identified key outputs for its first year –including a website hosted by FUSE (the Centre for Translational Research in Public Health, a collaboration between the five North East universities), a mapping exercise of existing sexual health research in the region and an inaugural Research Practice event to share key findings and plan future projects.
Discussion/conclusion We have identified an enthusiasm for sexual health research in the region, and hope that the network will draw together colleagues working in different fields who may not be aware of the range of work being carried out across the region. We hope that by identifying research questions that are locally meaningful, and by offering support from colleagues with expertise in the field, we will generate research that will inform sexual health practice and commissioning, reduce duplication and ultimately improve the sexual health of people in the North East and beyond.

P147 A TRUST-WIDE AUDIT ON PELVIC INFLAMMATORY DISEASE MANAGEMENT IN A GENITOURINARY MEDICINE SETTING

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10.1136/sextrans-2015-052126.190

Background/introduction Diagnosis and management of pelvic inflammatory disease (PID) in the genitourinary medicine clinic can be challenging. Optimising management is essential in preventing potential sequelae. The national BASHH PID audit (2012) indicated that adherence to guidelines was inconsistent.
Aim(s)/objectives To audit PID management to help inform introduction of new trust guidelines.
Methods Retrospective case note review of all patients with a PID clinic code over six months at three clinics across the trust.
Results Of 184 cases identified, 99.5% of patients had either one or more of PID symptoms: lower abdominal pain, dyspareunia, abnormal bleeding, vaginal discharge. 92% and 97.8% of patients underwent microscopy and STI screening respectively. 16 tested positive for chlamydia, 4 for gonorrhoea, 5 for herpes simplex virus, 2 for trichomonas vaginalis, 47 for bacterial vaginosis (BV), 8 for urinary tract infection (UTI) and 10 for candida. 61% received a recommended treatment regimen, with up to 20 different treatment regimens prescribed. 44% of patients attended for follow-up after two weeks.
Discussion/conclusion In this cohort, there were relatively few STI diagnoses, with BV being the most likely microbiological diagnosis. There was wide variation in prescribing practice and adherence to local and national guidelines. Diagnostic criteria for PID were simplified and disseminated at a trust-wide meeting. New trust guidelines were introduced taking local resistance patterns and national guidance into account.

P148 LOST IN TRANSITION: USER VIEWS ON THE UPPER AGE LIMIT IN ACCESSING CONTRACEPTION AND SEXUAL HEALTH SERVICES

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10.1136/sextrans-2015-052126.191

Background/introduction In 2008 Integrated Contraception and Sexual Health (CASH) Services for those under 25s were launched at community and level-three sites. The age cap of 25 was linked to Chlamydia screening targets.
Aim(s)/objectives Staff highlighted concern regarding older clients and young people under 18 accessing services simultaneously. It was decided to consult user views before changes were made.
Methods Questionnaires were given to those under 25 attending CASH and level-three sites with choice regarding service access and age limit, 18, 20 or 25 and whether they had attended during a dedicated YP session.
Results 295 respondents; 41 male (13.9%). 2/14 <16s (14%), 9/57 <18s (16%), no 18–19 years olds and 10/156 >20s (6.4%) identified as attending during a dedicated YP clinic. 9/15 <16s (60%), 41/58 of <18s (71%), 52/66 18–19 years old (79%) and 125/156 of >20s (79%) preferred the age limit of 25.
Discussion/conclusion Surprisingly the majority of respondents from all age groups preferred 25 to be the maximum age for young people's CASH services. A small number of respondents were under 16 and further work with younger clients to address hidden concerns may be indicated. Older YP still preferred YP-orientated sessions however the majority of respondents attended out of dedicated young people session times highlighting the need for mainstream services to offer a young people friendly service during all sessions.

P149 DISCUSSING MENTAL HEALTH WITH YOUNG PEOPLE ATTENDING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

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10.1136/sextrans-2015-052126.192

Background/introduction Within Sexual and Reproductive Health (SRH) clinics identification of Mental Health (MH) problems is an important part of a consultation with young people (YP).
Aim(s)/objectives To review the number of YP who had documentation of a conversation regarding MH.
Methods Electronic patient records of 103 attendees were selected at random and reviewed.
Results MH discussion was documented in 81% (26/32) of <16s, 67% (n = 20/30) aged 16, 37% (n = 15/41) of those aged 17–18 years. Of these Child and Adolescent MH Services (CAMHS) were accessed by 23% (6/26) <16s (2/6 lost FU), 15% (n = 3/20) aged 16 and 7% (n = 1/15) aged 17–18 years. Of these ten disclosed the following specific disorders ADHD (2), self-harm (3), depression (2), anorexia and past sexual abuse (1) and conduct disorder (1), suicidal thoughts (1). 3/9 aged 16 and under who had accessed CAMHS disclosed sexual abuse.
Discussion/conclusion Sexual health is an important access point for YP with mental health problems, new or lost to follow up and may be associated with a disclosure of sexual abuse. Significant pressures exist in CAMHS services. Shared clinical experience and robust links between sexual health, CAMHS, general practice and youth services with appropriate referral pathways are important. We recommend training for all SRH staff should include: skills in eliciting MH problems in all consultations with YP, awareness of common MH problems in adolescence and knowledge of local service configuration including thresholds for referral to appropriate providers.

P150 CREATING OPPORTUNITIES FROM LOCAL AUTHORITY COMMISSIONING: EARLY INTERVENTION PATHWAY IN YOUNG PEOPLE'S SEXUAL HEALTH SERVICES

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Background/introduction Young people (YP) seen within sexual health services (SHS) may not meet referral thresholds for traditional social care measures but could benefit from improved links to early intervention services (EIS) such as targeted youth support.
Aim(s)/objectives The aim was to assess needs of attendees to inform service delivery and review use of a local safeguarding assessment proforma and review concerns identified.
Methods We reviewed a random selection of 103 records from attendees 18 or younger attending in 2013 identified by the clinic management system.
Results 18 male (17.5%). Where documented 24/68 (35%), 13/39 (33%) and 34/44 (77%) reported current smoking, drug and alcohol use respectively. 32 <16s had a proforma including decision regarding referral to social care within 12 months (100%), 8 were known to social care (25%). 5 reported non-consensual sex (17%) and 10 reported searched at age 13 or younger (31%). No infections were diagnosed in <16s. 28/30 and 29/41 of those aged 16 (93%) and 17–18 years (71%) respectively had a completed proforma.
Discussion/conclusion YP attending SHS have a number of vulnerabilities that do not meet safeguarding intervention thresholds. We have developed a holistic approach by: developing pathways between SHS and EIS, recruitment of a Relationships Worker to provide targeted support and staff training in understanding and recognising additional needs and vulnerabilities which exist even in the absence of infections.

P151 REATTENDANCE RATES IN MEN PRESENTING WITH SYMPTOMS OF URETHRITIS – SHOULD WE BE DOING BETTER?

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Background Chlamydia and gonorrhoea are common causes of urethritis. Management is often based on an enhanced syndromic approach while awaiting results. This can necessitate prescribing to cover a range of potential pathogens, and result in uncertainty for patients. Point of care testing (POCT) for chlamydia and gonorrhoea in men with symptoms of urethritis could alter care pathways and reduce reattendance.
Aims To measure reattendance rates in men presenting with symptoms of urethritis. To identify reasons for reattendance including those that could be mitigated by POCT.
Methods All men with urethritis symptoms presenting over a three month period were identified using electronic patient records. Urethritis was defined as 5 pmnls/hpf on a Gram stained urethral smear. Reattendances within 30 days of initial clinic visit and reasons for reattendance were recorded for both microscopy-positive and negative groups.
Results 431 men with urethritis symptoms were identified in a 3 month period. 192 had confirmed urethritis on initial microscopy. 31% of microscopy-positive men and 42% of microscopy-negative men reattended at least once within 30 days of initial visit. Common reasons for reattendance were early morning smear (20%), persistent symptoms (18%), results (16%) and gonorrhoea test of cure (9%).
Discussion This service evaluation has identified high reattendance rates in men with urethritis symptoms. POCT could impact on reattendance rates in a number of ways. Pathogen-guided treatment may reduce antimicrobial failure and persistent symptoms. Same-day results could reduce results visits. Reassurance from negative same-day results may also have a role in reducing persistent symptoms.

P152 WHAT KIND OF INFORMATION DO PATIENTS WANT TO SEE IN SEXUAL HEALTH CLINIC WAITING ROOMS?

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Background/introduction All sexual health clinics have noticeboards and leaflets in their waiting rooms carrying a range of information, but little is known about the kind of information patients find most useful. This survey was designed to gain

insight into the type of information patients most prefer to see in order to enhance patient experience.
Aim(s)/objectives To conduct a patient survey of preferences for information provided in sexual health clinic waiting rooms.
Methods 133 consecutive patients attending the integrated clinic were asked to complete a simple questionnaire covering the following areas: (1) how much attention is given to the information available; (2) Which types of information are most useful; (3) Preference for pictures, written text or a combination; (4) Importance of information that can be taken away.
Results 53% looked at most of the information, 32% only read what looked interesting or relevant while 15% took little notice. Facts about STI's were the most useful (64%), followed by prevention messages (51%), contact details of other organisations/services (49%), information about local/national campaigns (41%) and boards with specific themes (e.g. Valentine's day, Fresher's Week) (33%). 55% preferred a combination of pictures and text, 41% mainly text and 37% mainly pictures. 74% attached a high importance to information which could be taken away.
Discussion/conclusion 85% of patients paid significant attention to the information presented in the waiting room. Patients found factual information about STI's to be most useful followed by prevention messages. There was a clear preference for messages that combined text with pictures.

P153 WATCHING THE TV: *TRICHOMONAS VAGINALIS* NAAT TESTING IN AN INNER CITY SEXUAL HEALTH CLINIC

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Introduction *Trichomonas vaginalis* (TV) is the commonest curable STI worldwide. UK prevalence is comparatively lower but TV remains an important cause of genital symptoms. National guidelines recommend NAATs for TV testing due to their high sensitivity. Since 2012 we have utilised Gen-Probe APTIMA TV assays for symptomatic females, males with recurrent urethritis and contacts.
Aims Assess the effectiveness of our current TV NAAT testing practice.
Methods Retrospective casenote review of patients tested for TV in an inner city sexual health clinic between 01/01/14–31/03/14.
Results 961 (882F, 79M) patients were included. Median age was 24 (range 15–67), 445 (46.3%) were White British. 6 (7.6%) of the men were MSM. 28 (2.9%) patients were TV NAAT positive (21F, 7M). 5 of them attended as TV contacts. 11 TV-infected females had positive microscopy. Comparing diagnostic modalities microscopy had inferior sensitivity (=0.524) but excellent specificity (=1) and NPV (=0.986). All TV-positive men were either symptomatic (4) or an asymptomatic contact (3). The TV-positive and TV-negative cohorts were compared:

Abstract P153 Table 1 *Trichomonas vaginalis*

	NAAT positive (n = 28)	NAAT negative (n = 933)	p Value
Median age	35.9	24.1	<0.00001
Black Caribbean	7	55	0.00005
Symptomatic	22	832	0.078829
TV Contact	5	11	<0.00001
Other STI present	8	245	0.784302

TV incidence was significantly associated with increasing age, Black Caribbean ethnicity and attending as a contact; concurrent STI diagnoses and evident symptoms were not.
Conclusion Our data demonstrates the superior sensitivity of NAATs over microscopy. Extending screening to asymptomatic patients is not warranted. We continue to focus TV testing on known at-risk populations.

P154 PROCESS EVALUATION OF THE 3Cs AND HIV PILOT: AN EDUCATIONAL PROGRAMME TO SUPPORT GENERAL PRACTICES DELIVER CHLAMYDIA SCREENING, CONTRACEPTION, CONDOMS AND HIV TESTING TO PATIENTS

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10.1136/sextrans-2015-052126.197

Background/introduction General practice (GP) offers a wide range of sexual health services, although provision varies across England. Educational support visits to GPs are effective in improving sexual health services. 3Cs and HIV is a national pilot that provided GP training for opportunistic offers of chlamydia testing, free condoms and information about contraceptive services to 15–24 year olds (i.e. 3Cs), plus HIV testing according to national guidelines.
Aim(s)/objectives To describe local authority (LA) and GP engagement with the 3Cs and HIV pilot using process evaluation measures.
Methods The training programme comprises two practice educational support visits, the first on 3Cs and the second on HIV testing. Data on LA and GP recruitment, retention and implementation of the training was collected throughout the programme.
Results In total, 56 LAs invited 2,532 practices to the programme, 461 agreed to participate. Data was returned by 46 LAs accounting for 405 practices (88%). Half of participating practices received at least one visit (255/461, 55%). Nearly a third of practices received only the 3Cs visit (143/461, 31%) and 24% (111/461) received both the 3Cs and HIV visits. More general practitioners than nurses attended the training (826 vs. 752), especially for the HIV sessions (263 vs. 211).
Discussion/conclusion Many practices reported an interest in receiving sexual health educational support visits, however a large proportion did not start or complete the full programme. This highlights the difficulties sustaining GP engagement over time, which may be due to competing priorities for protected learning time. Future programmes may need to be shorter.

P155 "TIME IN CLINIC" SURVEY TO EVALUATE THE POTENTIAL FOR USE OF ONLINE REGISTRATION

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10.1136/sextrans-2015-052126.198

Background/introduction We continuously try to improve patient experience in our integrated service. After introducing a "slot" booking in system, patients spent 40% less time in clinic, though still report spending too long in surveys. We wanted to

map patient journey, identify potential improvements, including introducing on-line booking and e-triage.
Aim(s)/objectives To evaluate 1) the proportion of patients whose visit is >2 h from entering clinic to completion of the clinical encounter 2) effectiveness of patient completed triage.
Methods Pilot data was collected over 1 day (1 week to follow). Reception staff recorded patient first arrival, and administered a patient completed questionnaire recording the timing of the clinical encounter. Questionnaires, triage forms and case notes were reviewed.
Results 49 patients attended (23 male, 26 female). Complete data were available for 15(65%) males and 18(69%) females (Table 1). 58% of patients needed to allow >2 h to attend clinic (61% symptomatic, 57% asymptomatic). Self-triage was available for 45(92%) patients, with concordance between clinician and patient in 41/45 (91%).

Abstract P155 Table 1 Time in clinic: median hours (range)

	Male	Female	Total
Duration: clinic visit	1.55 (0:55–2:49)	2.11 (1:05–4:11)	2.04 (0:55–4:11)
Time before consultation	1.17 (0.35–2.10)	1.34 (0.40–3.37)	1.30 (0.35–3.37)
Duration: clinical encounter	0.30 (0.08–2.04)	0.30 (0.05–2.00)	0.30 (0.05–2.04)
Duration: clinic visit, symptomatic	1.50 (1.06–2.08)	2.18 (2.05–3.57)	2.05 (1.06–3.57)
Duration: clinic visit, asymptomatic	2.10 (1.30–2.49)	2.00 (1.05–4.11)	2.07 (1.05–4.11)

Discussion/conclusion Provisional data shows: 1) patients spend too long in clinic and developments including online booking could potentially reduce this, and 2) most patients are able to triage themselves.

P156 HOW MUCH ANTIRETROVIRAL THERAPY DO WE DISCARD?

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Background/introduction Current audit standards for antiretroviral therapy (ART) prescribing do not include standards for quantity dispensed.
Aim(s)/objectives 1) Establish a clinical standard for the quantity of ART to dispense when initiating or switching therapy. 2) Make a qualitative assessment of avoidable discards of ART. 3) Audit prescribing against existing BHIVA standards.
Methods An HIV care unit's database was interrogated to identify 350 patients who had initiated or switched ART over 2 years to August 2014. ART prescribing and outcomes data were collected retrospectively from 110 randomly selected patients.
Results 58.2% (n = 64) switched therapy; 57.8% (n = 37) as a result of toxicity, 15.6% (n = 10) resulting from rationalisation of therapy and only 3.1% (n = 2) for virological failure. The median quantity of ART dispensed at initiation or switch was 8 weeks (IQR; 8–12) supply; discarded at switch was 1.5 days (IQR; 0–29.75) supply. Mean (SD) cost of discarded ART after switch was £311.11 (£11.54); median was £20.63 (IQR; £0-£334.94). Reasons for discard for patients in the highest cost quartile are displayed in Table 1.
Discussion/conclusion Dispensing 8 weeks of ART at initiation or switch results in a lower than expected cost of discarded ART. There is limited potential for reduction in avoidable discards by addressing the small number of high cost cases.

Abstract P156 Table 1 Reasons for discard in highest cost quartile

Indication	Number of patients	Percentage of patients	Total cost (£)
Toxicity	6	37.5%	7024.08
Renal impairment	5	31.25%	5578.81
Patient request	2	12.5%	1308.94
Drug interaction	1	6.25%	756.84
Unclear	2	12.5%	2166.21

P157 IDENTIFYING THE DEMAND FOR "TEST-NO-TALK" GU SERVICES IN A RURAL SETTING

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10.1136/sextrans-2015-052126.200

Background/introduction GU services are under growing pressure to provide resource-efficient screening programmes. Test-no-talk (TNT) services are gaining interest as an affordable method of asymptomatic screening.
Aim(s)/objectives Identify the proportion of our patients who might be suitable for TNT services.
Methods We retrospectively reviewed the notes of 271 new/rebook patients who were tested for any combination of chlamydia, gonorrhoea, syphilis and HIV. Patients were excluded if they had any other service or diagnosis code apart from C4. For the purpose of the study, patients were deemed unsuitable for TNT services if they were symptomatic, <18 years of age, at high risk of HIV, a recent victim of sexual assault, at risk of pregnancy, a man with a same sex partner (MSM), if female, menstruating at the time of the appointment. TNT suitability was analysed using chi-squared tests.
Results 134 men and 137 women, median age 30 and 23 respectively, were included. 202 patients (75%) were asymptomatic, of these 110 (54%) were suitable for TNT services). The association between gender and symptoms was statistically significant: 81% of men being asymptomatic compared to 69% of women (p = 0.024). 54 (49%) patients were examined, altering the management of 9. There were no statistically significant associations between age or gender and TNT suitability (p = 0.97 and p = 0.06 respectively).
Discussion/conclusion Approximately 40% of our patients undergoing STI screening could be directed towards TNT services, with careful risk-assessment at booking. Our results suggest it is safe to exclude physical examinations in TNT clinics as they rarely alter the management.

P158 EXPLORING THE FEASIBILITY OF SHORTENING THE NATIONAL CHLAMYDIA SCREENING PROGRAMME TIME TO TREATMENT STANDARD

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Background/introduction Timely treatment of sexually transmitted infections (STI) is an important factor in reducing sequelae and transmission. British Association for Sexual Health and HIV

(BASHH) standards for the management of STIs recommends treatment "in as short a timescale as possible". The National Chlamydia Screening Programme (NCSP) sets a key indicator of treating 95% of those testing positive within six weeks of test date.

Aim(s)/objectives To explore the feasibility of services achieving a shorter time to treatment standard.

Methods National audit data from the most recent NCSP turnaround time audit were used to explore how many services would meet treatment targets of three and two weeks from test date.

Results The current time to treatment standard of 95% treated within six weeks was achieved by 39% of providers (91% of positive patients receiving treatment within six weeks, due to large services having a proportionately greater impact). Using the targets of three and two weeks this fell to 28% and 4% of providers, respectively. However, this represents 88% of patients treated within three weeks and 76% within two weeks (Table 1).

Abstract P158 Table 1 Chlamydia treatment

Timescale	% of patients treated within the timescale	% of providers with 95% of patients treated within the timescale
Six working weeks	91%	39%
Three working weeks	88%	28%
Two working weeks	76%	4%

Discussion/conclusion 88% of positive patients were treated within three weeks from test date even though only 28% of providers would have been able to meet this time to treatment standard. Meeting a shorter time to treatment standard would be challenging but could help to drive quality improvement and may form part of updated standards for the NCSP.

P159 SEXUAL HEALTH SERVICES ARE IDEALLY PLACED TO MANAGE VULNERABLE YOUNG PEOPLE?

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10.1136/sextrans-2015-052126.202

Background/introduction Identifying and assessing the risk of child sexual exploitation (CSE) in young people is a fundamental role of sexual health clinics. The 'Spotting the signs' proforma developed by BASHH recommends assessing all those <18 yrs for risk factors.

Aim(s)/objectives The aim of this audit was to review those <18 yr olds attending the GU clinic in Brighton assessed as medium or high risk to investigate the areas of concern, the appropriateness of interventions and follow up.

Methods EPR records for all <18 yr olds between 1/4/14 and 31/10/14 were reviewed.

Results 56 patients identified, 86 attendances. 36/56 (64%) were 16–17 yrs. 48/56 (86%) were female. 23/56 (41%) were seen in the Young Person's Clinic, the rest seen throughout the service. Concerns included: sexual assault/non-consensual sex 41%, drugs and alcohol 39%, difficulties at home/in care 37%, mental health 37% and partner age/coercion 11%. 20% had concerns in 3 areas. Interventions: 24/56 (53%) already had social work or other agency involvement, 27% were referred to agencies for the first time as a consequence of their visit to the clinic. Further clinic follow up was arranged in 33/56 (59%). All patients had a clear action plan.

Discussion/conclusion This audit suggests that older young people (16–17 yrs) have significant risk factors; the same vigilance accorded to under 16's needs to be applied to this group. Sexual Health clinics are well placed to both recognise those at risk and provide ongoing support and referral.

P160 WHAT IMPACT DID THE XX COMMONWEALTH GAMES HAVE ON STIs AND SEXUAL HEALTH SERVICES IN GLASGOW?

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10.1136/sextrans-2015-052126.203

Background/introduction An estimated 600,000 spectators, volunteers and athletes from over 70 countries visited Glasgow for the XX Commonwealth Games, held between 23 July and 3 August 2014, doubling the city's population.

Aim(s)/objectives We sought to investigate the impact of the Games on the number of acute STIs and on service activity in core specialist sexual health services, which offer free walk-in access.

Methods We interrogated our city-wide electronic patient record system (NaSH) to measure service activity, the number of acute STIs and PEPSE prescriptions between the 9th July and the 31st August 2014. We compared these to the same time period in 2013. We prospectively asked all new clinic attendees if they were in Glasgow for the Games.

Results

Results	Games 2014	Games 2013	Difference
Total Attendances	14,973	16,440	−8.9 (↓)
New Registrations	1,986	2,150	−7.6 (↓)
Acute STI episode	623	693	−10.1 (↓)
Gonorrhoea	78	81	−3.7 (↓)
Chlamydia	372	428	−13.1 (↓)
Early syphilis	15	14	7.1 (↑)
NSU	83	78	6.4 (↑)
Trichomonas	3	2	50.0 (↑)
Primary HSV	64	79	−19.0 (↓)
PEPSE prescriptions	8	11	−27.3 (↓)

Of the 1496 attendees who responded, just 1.7% (26) were in Glasgow solely for the Games.

Discussion/conclusion Despite the huge influx of visitors, service activity and overall acute symptomatic STI incidence decreased by around 10% during and after the Games compared to 2013. We found no evidence that large sporting events increase demand for sexual health services or cause a rise in acute STIs.

P161 SEXUAL HEALTH IN GENERAL PRACTICE: DO GP PRACTICES COMPLY WITH BASHH GUIDELINES?

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10.1136/sextrans-2015-052126.204

Background The passing of the Health and Social Care Act 2012 committed to more services in the community provided closer to home and by GPs. Therefore most GP practices are commissioned to provide Level one STI screening.

Aim The aim of this Audit was to assess if STI screening in a single Level 1 GP surgery met BASHH Guidelines.
Methods A retrospective audit of 15000 patients was carried out over an audit period of 2 years. Notes of patients coded with a positive test result for Chlamydia or Gonorrhoea were reviewed and clinical practice compared to BASHH guidelines in 4 areas:

- Method of investigation
- Antibiotic treatment
- Screening offered
- Partner notification.

Results

Audit standard	Percentage of patients with positive diagnosis of Chlamydia/Gonorrhoea
Gold standard investigation used for diagnosis	62%
Appropriate antibiotic used	100%
Screening for HIV and Syphilis performed or offered	19%
Risk assessment/screening performed for Hepatitis	4%
Partner notification discussed at time of treatment	79%

Discussion Results would suggest that clinical practice does not always meet BASHH guideline recommendations. Also of note is the low number of diagnoses, a total of 29 in the 2 year audit period. During this time there were 7636 patient encounters of people aged 17–24, all of which are potential screening/health promotion opportunities. Missed opportunities to promote sexual health or perform a full sexual health screen could lead to a higher prevalence of unrecognised sexual health conditions in an at risk group, where extreme rurality can make access to local sexual health clinics challenging.

P162 DO STAFF IN SEXUAL HEALTH FEEL COMPETENT SEEING MEN POST INTEGRATION OF SERVICES?

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10.1136/sextrans-2015-052126.205

Background/introduction Integration of Genitourinary Medicine and Sexual and Reproductive Health is happening across Scotland. This means that some staff previously seeing only women are now dealing with men.
Aim(s)/objectives We wanted to identify if staff felt competent and trained to manage male patients.
Methods A link to a web based survey (10 questions) was emailed to all clinical staff in two services in Scotland who provide specialist care to a similar size of population but have a different approach to clinic service provision.
Results There were 16 responses from centre 1 and 21 responses from centre 2. 68% (centre 1) had routinely seen male patients prior to integration versus 33% (centre 2.) 81% (centre 1) and 66% (centre 2) said they felt comfortable taking a history and examining male patients. 100% (centre 1) but only 71% (centre 2) said they had access to local and national guidelines in the clinic. 75% (centre 1) and 62% (centre 2) felt they had enough training for managing straightforward cases in both heterosexuals and MSM. 14% (centre 2) felt they had enough training for only heterosexual men but not enough for MSM. 25% (centre 1) and 24% (centre 2) felt they hadn't had enough training for managing either heterosexual males or MSM.
Discussion/conclusion The survey highlights that there is further training needed within both centres so that staff feel confident in managing both heterosexual males and MSM.

P163 YOUNG ADULTS' VIEWS OF BEING OFFERED RE-TESTING FOR CHLAMYDIA AFTER A POSITIVE RESULT: RESULTS OF A 2014 ONLINE SURVEY

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10.1136/sextrans-2015-052126.206

Background/introduction Individuals who test positive for chlamydia are at increased risk of subsequently testing positive. NCSP standards recommend offering re-testing three months after treatment completion. Concerns have been raised that re-testing could undermine prevention messages.
Aim(s)/objectives To elicit young adults' views on the acceptability, and their preferred method, of being offered re-testing, as well as their reaction to and understanding of re-testing.
Methods We conducted a cross-sectional web-based anonymous survey of 1,218 young adults aged 16–24 resident in England with a history of chlamydia testing. Respondents were recruited through a market research panel, and Likert-scale questions were based on a young adult focus group.
Results The most acceptable and preferred methods of being offered re-testing were being given an appointment with initial test result (75%, 914/1,218 acceptable; 17%, 204/1,218 preferred) and being sent a text message reminder (72%, 875/1,218 acceptable; 20%, 244/1,218 preferred). Most said they would welcome an offer of re-testing (84%; 1024/1,218) and understand why they were offered this (82%, 994/1,218). Most agreed that if they were offered re-testing they would be more likely to complete the course of chlamydia treatment (83%, 1007/1,218) and use condoms with their partner until the test (80%, 970/1,218). Most disagreed that that they would be more likely to have one-night stands (63%, 772/1,218) or discourage their partner to get tested (60%, 735/1,218).
Discussion/conclusion Young adults report they would welcome an offer of re-testing and understand the reasons for being offered this. There was little evidence that it would increase sexual risk behaviour.

P164 DOES A WALK-IN FOLLOW-UP CLINIC FOR GENITAL WARTS DECREASE CLINIC NON-ATTENDANCE RATES?

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10.1136/sextrans-2015-052126.207

Background BASHH guidelines recommend a follow-up review in the management of some sexually transmitted infections; however, patient non-attendance for booked follow-up appointments leads to inefficiency in service provision. In 2013 we reviewed our booked follow-up appointments and found our

non-attendance rate was 31%. The condition with most frequent non-attendance was genital warts, at 38%. In response to this, a specific walk-in warts review (WWR) clinic was introduced and its impact reviewed.

Methods A retrospective review of non-specialist doctor and nurse follow-up appointments for 2 weeks (19/5/14–1/6/14), 6 months following the establishment of the WWR clinic, compared to 2 weeks prior to its introduction (25/2/13–10/3/13).

Results In total 85 patients were given a booked non-specialist follow-up appointment in the 2014 sample, compared to 103 in the 2013 sample. 19 patients attended for warts review (15 in the WWR clinic, 4 booked appointments) in the 2014 sample, compared to 12 patients who attended their booked warts review in the 2013 sample. Overall the non-attendance rate for non-specialist booked reviews was 28% in the 2014 sample, compared to 31% in the 2013 sample ($p = 0.68$). Non-attendance in the 2014 sample was most frequent for gonorrhoea test of cure, blood tests and vaccines (21%, 13% and 13% of non-attendees, respectively).

Discussion Overall the non-attendance rate for follow-up appointments was not significantly lower following introduction of the WWR clinic. However convenience for patients has improved. Further work is needed to ascertain the optimal way of delivering best practice clinical care whilst ensuring efficient service provision.

Abstract P165 Table 1 Men attending sexual health clinics

	Heterosexual %	MSM %
Age at first attendance		
15	0.48	0.18
16–19	10.01	5.13
20–24	26.37	18.06
25–34	35.87	35.01
35–44	15.37	22.14
45–64	10.80	17.73
65	1.09	1.75
No. of attendance in 365 days		
1	65.66	39.71
2	19.88	19.89
3	7.03	13.25
4	3.20	8.97
5	4.22	18.18
Visit frequency, median (IQR)	1 (1–2)	2 (1–4)
Attendance outcomes		
Test-only	41.44	21.29
Any-STI	22.17	13.88
Non-STI	3.41	1.77
Other-GU-service	6.70	19.99
Other	31.93	49.23

P165 DIFFERING TRAJECTORIES OF SEXUAL HEALTH CLINIC (SHC) ATTENDANCE IN MEN-WHO-HAVE-SEX-WITH-MEN (MSM) AND HETEROSEXUAL MEN: CAN WE USE THESE TO PLAN SERVICES?

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10.1136/sextrans-2015-052126.208

Background Understanding why patients attend SHCs can inform service development.

Aims To describe SHC attendance patterns amongst heterosexual men and MSM.

Methods Heterosexual and MSM first attending SHC in 2012 were identified through the GUM Clinic Activity Dataset-v2 and followed for 365 days. Attendance frequency and outcomes were recorded. Attendance outcomes were classified: 'test-only' for negative sexually transmitted infection (STI) testing (chlamydia, gonorrhoea, syphilis, HIV) and no other service/diagnosis; 'any-STI'; 'non-STI' for other conditions; 'other-GU-service' such as health advice, post-exposure prophylaxis/vaccination; and 'Other' episodes not requiring treatment.

Results 809,106 attendances were identified among 438,609 men (81.37% heterosexual, 12.96% MSM). The Table describes age, visit frequency and attendance outcomes. Multivariate Poisson regression adjusted for age, ethnicity, and area-level deprivation demonstrated that attendance frequency was greater amongst MSM (Incidence Rate Ratio 1.69, $p < 0.001$) and men with any-STI at first attendance (IRR 1.67, $p < 0.001$).

Discussion Men who are appropriate for clinically and cost-efficient pathways, such as telephone review and home testing, could be identified at first attendance and offered customised care pathways stratified by risk.

P166 "IF YOU BUILD IT, THEY WILL COME": HOW THE TARGETED LOCATION OF A SEXUAL HEALTH CLINIC WITHIN THE SOCIAL HEART OF AN AT RISK COMMUNITY CAN SIGNIFICANTLY INCREASE THE DETECTION AND MANAGEMENT OF INFECTIONS

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10.1136/sextrans-2015-052126.209

Background/introduction A 2009 decision to relocate a sexual health and HIV clinic to an area with the highest density of gay venues in Europe was based on the belief that positioning a service directly where a high risk and vulnerable population socialised would facilitate regular sexual health screening for men who have sex with men (MSM), improve the early detection of HIV and other infections, and reduce onward transmission.

Aim(s)/objectives This study examined whether the relocation had led to the anticipated increase in overall attendances and pathology specifically in MSM beyond the increase in national STI rates reported by Public Health England. As the relocation effect cannot be directly measured, any significant discrepancy between the two rates could be used as a proxy for success.

Methods Attendances and infection rates for 2008 at the former clinic were compared with those for 2013 at the new clinic (from KC60 codes). The overall infection increase was then compared with the increase in STI rates reported nationally by Public Health England between 2008 and 2013. The specific proportion of infections in MSM was compared with the national data for 2013.

Results Attendances increased by 22% from 56,181 to 68,395, with 61% of patients in 2013 reported as homosexual. The increase in infections significantly exceeded both this and rates reported by PHE, with 84% of infections reported in MSM.

Abstract P166 Table 1 If you build it, they will come

Infection	Number of diagnoses 2008	Number of diagnoses 2013	Clinic increase 2008–13	PHE increase 2008–13	2013 Clinic STI in MSM	2013 PHE STI in MSM
Syphilis	116	516	**345%**	13%	**94%**	81%
Gonorrhoea	208	3055	**1369%**	95%	**95%**	63%
Chlamydia	539	2346	**335%**	−8% (in GUM settings)	**66%**	17%
HIV	175	381	**118%**	−17%	**87%**	49%

Discussion/conclusion There was a significant disproportionate rise in the detection of infection compared to attendances. This suggests the intervention was successful at reaching the high risk groups targeted.

P167 WEEKLY CASE REVIEW AND TELEPHONE FOLLOW UP TO IMPROVE MANAGEMENT OF PELVIC INFLAMMATORY DISEASE (PID) IN A SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.210

Introduction Previous audits of our management of Pelvic Inflammatory Disease (PID) have shown poor compliance with guidelines, including missing pregnancy testing (PT) in 47% and no follow up in 66%.
Aims To improve management and follow up of PID.
Methods We introduced a weekly notes review of all PID cases attending our sexual health service. Clinicians received feedback about incorrect antibiotics, or failing to do pregnancy testing (PT). An unsolicited phone call was made to patients not attending 2 week review, to discuss symptoms, treatment completion, partner treatment and abstinence. This is a review 4 months September–December 2014.
Results 101 patients were treated for PID. 25% did not have a PT documented,. Overall 46% received recommended antibiotics (30% in the first 2 months, 64% in the last 2 months). 29% attended for review. Phone calls reached 28% of the remaining patients. 90% of patients contacted or attending had completed treatment. 53% still had symptoms
Discussion Weekly review allowed for regular feedback to clinicians about documentation and management. Pregnancy testing rates were improved on previous results, though still of concern. Antibiotic prescribing was initially poor, probably due to a recent change in protocol. This improved over the course of the 4 months, suggesting the value of weekly targeted feedback. Unfortunately, phone calls were often unsuccessful, though patients were happy to receive calls. A significant number of patients still had symptoms, undermining our previous assumption of cure where patients failed to attend follow up. To improve telephone follow up, pre-arranged times or methods of contact may be worth trialling.

P168 INTRODUCING CHANGE, IMPROVING PRODUCTIVITY IN TIMES OF AUSTERITY…CAN IT BE DONE?

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10.1136/sextrans-2015-052126.211

Background/introduction A number of service changes (expanded opening hours, increased access to contraception) were implemented within existing resource and were successful at reversing GUM declining attendances trend. We describe and evaluate a "grass roots" process used in our clinic to do this.
Aim(s)/objectives The aims were to evaluate:

- Impact of the process on staff motivation and team dynamics
- Staff perspective on the change process

Methods Clinical leads outlined change triggers and engaged team in vision development during a series of away mornings. Subsequently, staff members took lead on designing, planning and implementation of work streams. All staff were invited to complete a survey monkey questionnaire exploring personal experience of change, impact of change on team dynamics and job satisfaction 3 months afterwards.
Results 17/19 potential respondents completed the questionnaire either fully or partially. 9–11/17 (53–65%) felt they were very supported in the process. 11–14/17 (65–82%) felt the team work was collaborative and problem solving. 7/14 had no change in their job satisfaction, rated as good. 2/14 rated their job satisfaction as very poor before the process, but no one (0/14) did so afterwards. No staff rated their job satisfaction as excellent before the changes and 1/14 did so afterwards. Factors cited by staff to positively influence the process were feeling valued, a clear vision, using the SMART goal model to problem solve. 9/17(53%) would recommend this process to other departments.
Discussion/conclusion We have delivered effective change whilst empowering individuals and teams and improving patient care, all within resource.

P169 EVALUATION OF A PATIENT INFORMATION LEAFLET DESIGNED TO AID THE PATIENT EXPERIENCE OF A NEWLY INTEGRATED SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.212

Background/introduction Four services merged to create one new integrated sexual health (SH) service following a tender process. A new hub opened and six spoke clinics remained in existing locations. To address concerns about the implementation of integration a patient information leaflet (PIL) was designed explaining the new service (including how clinics might be different for returning patients, all services offered, and explanation of STI/HIV testing).
Aim(s)/objectives To evaluate the PIL.
Methods The new PILs were handed to all patients across the service (excluding two young persons services) at reception to read before seeing the clinician. During the first two weeks of role out patients were asked to complete a paper feedback form about the PIL.

Results 92 feedback forms were returned (20 [22%] from the hub and 72 [78%] from four spokes). 4 (5%) males: 86 (96%) females, median age 30 years (range 16–64). Knowledge of services offered improved from median 4/10 (range 1–10/10) to median 10/10 (range 1–10/10) after reading the leaflet. 33/66 (50%) patients not originally attending for an STI screen would consider or agree to screening after reading the leaflet (36/82 [44%] for HIV testing respectively). The leaflet received an overall rating of median 10/10 (range 5–10/10).
Discussion/conclusion Overall the leaflet was well received and improved patient's knowledge of services offered, and uptake of STI/HIV testing. Females provided the majority of feedback most likely due to spokes previously providing primarily contraceptive services. More work needs to be done to encourage males to attend the spoke clinics.

P170 ASSESS THE RISK BEHAVIOURS AND SAFER SEX PRACTICES AMONG MALE ATTENDEES IN A SEXUAL HEALTH SETTING

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10.1136/sextrans-2015-052126.213

Background/introduction During the year 2011, 8511 males received services from the sexual health clinics island wide. At present there is only limited information on the risk behaviours of male attendees. Information on risk behaviours related to STI /HIV transmission is helpful in planning suitable prevention interventions.
Aim(s)/objectives The objectives were to determine the sexual partners responsible for transmitting STI/HIV and to understand the practice of safer sex.
Methods Study was a clinic based prospective study conducted for a one year period using an interviewer administered questionnaire.
Results 983 attendees were interviewed. 50% admitted sex with a casual female, 12% with a casual male, and 13% with CSW (commercial sex workers). 20.5% used alcohol frequently and 5.9% used drugs and 1.4% injected. 6.7% gonorrhoea, 8.2% nonspecific urethritis (NSU), 7.5% herpes and 0.7% HIV were transmitted by CSWs. Female casual partners were responsible for 3.7% gonorrhoea,8.3% NSU, 6.6% herpes and 0.8% HIV. MSM contacts were responsible for 10.6% of gonorrhoea, 4.5% NSU, 7.6% of infectious syphilis and 0.8% of HIV. Only 9% used condoms correctly. Non use of condoms were not due to unavailability but for other reasons as worried about satisfaction (24.6%) and faith in the partner (25.6%).
Discussion/conclusion Casual partners for unsafe sex is a concern. MSM and CSW are remained as an important source of infection. More males contracted infections via casual partners. Low condom use remains another concern. Therefore strategies used for prevention need to be revisited also emphasising on general population where casual partners represent.

P171 ACTIVE RECALL OF HIGH-RISK MSM BY TEXT MESSAGE

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10.1136/sextrans-2015-052126.214

Background/introduction PHE recommends high risk MSM test 3 monthly. We introduced recall of high-risk MSM for HIV/sexually transmitted infection (STI) testing by short message service (SMS).
Aim(s)/objectives To assess effectiveness of SMS recall by re-screening rate and number of incident STIs.
Methods From January 2014, MSM who reported condomless anal intercourse with a non-regular partner in the last 3 months were offered an SMS 3 months later inviting them to rescreen. We compared the testing rate of the first 100 eligible MSM in the 12 weeks following SMS with a historical control group of 100 MSM who attended in January 2013. Proportions were compared using a two-tailed Z-test.
Results Median age was 30 y (IQR: 26–36 y) for SMS group and 29y (IQR: 25–35 y) in controls. 44% of SMS group retested compared with 19% of controls ($p < 0.001$). 32% of SMS group were diagnosed with an STI at retest (14/44; SMS) vs. 16% (3/19; control). HIV was diagnosed in 2 of SMS group and 1 in control group at retest.
Discussion/conclusion Active SMS recall for MSM is associated with a statistically significantly higher retesting rate. The high proportion of MSM with STIs at re-screening reinforces the importance of active recall, especially using SMS reminders which are cheap and easy to facilitate.

P172 IMPLEMENTATION OF ALCOHOL SCREENING IN PATIENTS ATTENDING A LARGE WALK-IN SEXUAL HEALTH SERVICE WITHIN LONDON

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10.1136/sextrans-2015-052126.215

Background UK national guidelines advocate a role for sexual health services to offer routine screening for high-risk alcohol consumption in patients. Screening for alcohol misuse and offering brief interventions in this setting has been shown to be acceptable to clinicians and patients. In August 2014 the Fast Alcohol Screening Test (FAST) was incorporated into the sexual history proforma in a London Genitourinary Medicine (GUM) clinic.
Aim An audit was undertaken to assess the use of the FAST tool and management of patients with a positive FAST result.
Methods A retrospective case-notes review of randomly selected patients attending the GUM clinic in October 2014 was performed. Information was collected on patient demographics, sexual history, sexually transmitted infections, completion of FAST tool and action dependent on outcome of risk assessment.
Results 169 case notes were reviewed: 55% female and 45% male, mean age was 30 (range 17–74) years. The FAST tool was completed in 87% (147/169) of case notes. Of patients screened, 86% (127) identified as low risk, 10% (15) increasing and 4% (5) high risk (hazardous drinkers). Of hazardous drinkers, 90% (18) had a documented action for risk reduction; 56% (10) had verbal advice documented, 22% (4) accepted written advice, 22% (4) accepted referral to a sexual health advisor.
Conclusion Clinician completion of the FAST tool within the sexual history proforma in a busy clinic was high, with some scope for improvement. Of the relatively low number of hazardous drinkers identified, most accepted only brief verbal advice in clinic.

P173 ROUTINE ENQUIRY FOR INTIMATE PARTNER VIOLENCE (IPV) ACROSS AN INTEGRATING SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.216

Background We have previously presented our review of routine enquiry (RE) for IPV in a genitourinary medicine (GUM) service. On-going integration with contraception services (CASH) combined with a new electronic patient record (EPR) in 2013 has prompted further review across the whole service (comprising 13 community clinics and the level 3 GUM service).
Aim Have these service changes impacted on our recommendation that RE is undertaken for all new patients? In addition, how many cases of IPV are we identifying?
Methods All new or rebook patients attending between 01/05 and 30/11/2014 where RE was documented were reviewed. Results: There were 17878 attendances (12316 new; 8724 female, 3590 male). The results are summarised below.

Abstract P173 Table 1 Routine enquiry for intimate violence

IPV routine enquiry	No of cases	%
Patient screened at least once	8614	70 (of new attendances)
Current issues documented	72 (68 female; 4 male)	0.8
Past issues documented	567	6.6

58% of those identified with current issues of IPV had attended the level 3 GUM service. In the majority, support was already in place. 567 had documentation of past issues of IPV, of which 58 had on-going needs identified. Experiences included child sexual abuse, stalking and social media harassment.
Discussion Routine enquiry for IPV is feasible across an integrated service and identifies a range of issues. The proportion screened appears stable (71% in 2013 and 70% in 2014). The scale of the problem in our population is alarming and highlights the need for adequate staff training and clear referral pathways.

P174 IMPROVING IMPLANT RETENTION RATES IN AN INTEGRATED SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.217

Background Subdermal implants (SDI) are cost effective when used for the recommended time. Early removal of SDI reduces cost effectiveness and we were aware anecdotally that this was an issue within our service. Data was lacking however. Subsequently removal rates at 3 and 6 months have been included within our Public Health Quality Contract (PHQC). Various strategies were implemented to reduce early removal. These included: improving the consent process by amending consent form; encouraging the use of additional methods to manage unscheduled bleeding; starting a dedicated implant removal clinic in February 2014.
Aim Have the outlined service changes impacted on SDI removal rates?
Methods Data from our PHQC was obtained from 2014–15. This measured SDI removal rates as a proportion of the total SDI fitted by our service.
Results In April 2014 the 3 months removal rate was 3.53%. By November 2014 it had fallen to 0.34%.
Discussion The strategies that were implemented appear to have had the desired effect. Care was taken to ensure staff gave patients the right information prior to fitting to ensure that their expectations of how any side effects would be managed was clear at the outset. The implant removal clinics were initially slow to get established and now are fully booked for months in advance. This has led to some criticism that patients are now unable to get their implants removed easily. The challenge moving forward is to ensure that patients have any symptoms managed promptly whilst keeping retention rates high.

P175 THE IMPACT OF INTRODUCING AN ASSISTANT PRACTITIONER TO THE HEALTH ADVISOR TEAM IN A BUSY URBAN SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.218

Background The role of Assistant Practitioner (AP) in the Health Advisor (HA) team is new and has not previously been described. It is unusual in that someone who has not had formal nursing or medical training is able to supply medicines to a patient. Our service set about developing this Agenda for Change band 4 role, with Drug and Therapeutic Committee approval, to support the clinical team.
Aim To evaluate the new role now that training is complete.
Methods List the tasks undertaken by HA and compare with those now undertaken by the AP.
Results

Traditional HA Roles	Delegated to AP
Supply Azithromycin for uncomplicated Chlamydia/contacts of (including in pregnancy)	✓
Carrying out simple Partner Notification (PN) for Chlamydia	✓
Recalling patients for treatment	✓
Following up patients via telephone calls	✓
HIV Point of Care Testing	✓
Motivational Interviewing	✓
Carrying out PN for STIs other than Chlamydia	×
Safeguarding Adults and Children	×
Support post Sexual Assault	×

Discussion The AP has proved to be a valuable additional role within our service. Rigorous training and robust protocols had to be developed but this now allows her to operate independently. Despite initial reservations about replacing a HA post with an AP of a lower band our clinical team are now supportive of this role and recognise that this delegation of tasks allows time to focus on more complex cases.

P176 THE ROLE OF DUTY DOCTOR IN AN INTEGRATED SEXUAL HEALTH SERVICES

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10.1136/sextrans-2015-052126.219

Background/introduction The duty doctor role was introduced into our integrated sexual health service in 2012 with the aim of improving patient flow through the clinic.
Aim(s)/objectives Three years on we wished to review the service and ensure it remains fit for purpose.
Methods We undertook an anonymous survey of clinical staff assessing if the duty doctor improved the service for patients and staff waiting for a second opinion; for staff teaching and learning and staff's confidence in duty doctor knowledge.
Results Twenty seven members of staff completed the questionnaire. When asked to rate the utility of the duty doctor on a scale of 1 to 10 (1-no use at all, 10-indispensable) the average response was 8. The majority thought the service was better or much better for patients and staff. Only 21% thought the service should be expanded. 72% of respondents have/would bypass duty doctor. 55% would approach the duty doctor for GUM but ask elsewhere for contraception. 47% would approach for contraception but ask elsewhere for GUM. Only 25% thought a separate contraception and GUM duty doctor was needed. The service was praised for its expert 2nd opinions, quick responses and the reassurance to patients. Common problems were that the doctors were hard to contact at times and occasionally doctor's gender was difficult for patients.
Discussion/conclusion The duty doctor is a valuable role, accessibility needs to be addressed but with the exception of increasing the pool of doctors who act as duty doctor the role should remain unchanged.

P177 DEVELOPING THE SEXUAL HEALTH WORKFORCE: DESIGNING AND DELIVERING TRAINING FOR HEALTHCARE ASSISTANTS

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10.1136/sextrans-2015-052126.220

Background Increasingly 'simple' sexual health services (e.g. asymptomatic screening) are provided by Healthcare Assistants (HCA's). There is no nationally accredited training for this staff group and clinical services usually provide in house training to develop their theoretical knowledge and skills.
Aim To develop and evaluate a course for HCA's working in sexual health.
Methods We designed a 2-day course covering 14 topics based on the structure of the STIF course. Content and learning objectives were devised using existing competencies and in consultation with the multi-disciplinary team. Nurses deliver the course using a mixed teaching methodology (lectures, role play and interactive workshops). Learning outcomes include:

Knowledge:

1. Understand the principles of asymptomatic STI testing
2. Understand issues relating to confidentiality, vulnerable patients and partner notification

Skills:

1. Feeling comfortable and competent taking a sexual history
2. Optimise care pathways with local relevant support services

Attitudes:

1. Understand the range of human sexualities, lifestyles and culture and their impact on transmission, prevention and counselling

Results The course has run on 2 occasions with a total of 18 attendees: both sexual health HCAs and practitioners from other specialities (e.g. A+E and gynaecology). All topics were well evaluated with a mean overall score of 4.55/5 (range 3.8–5). Free text comments were positive with specific reference to how "valuable", "useful" and "relevant" the course was.
Discussion We have designed, delivered and evaluated a successful sexual health course for HCAs that could easily be nationally accredited and delivered in other services and settings.

P178 SPECIALIST HERPES CLINICS: IS THERE ANY POINT?

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10.1136/sextrans-2015-052126.221

Background/introduction Specialist clinics have been introduced in a number of specialities, but patient benefits have proved difficult to demonstrate, despite increased investigations and costs. Genital herpes requires extensive counselling which previous studies have demonstrated is often of poor quality.
Aim(s)/objectives To assess the value of a specialist genital herpes clinic, in terms of patient satisfaction and outcomes, in comparison with a general genitourinary medicine clinic at a UK level 3 sexual health service in patients with a diagnosis of first episode genital herpes.
Methods 200 patient records of those attending a UK level 3 sexual health service with first episode herpes between 2012–2013 attending a specialist or general clinic were reviewed to assess initial management, complicating factors, and subsequent health seeking behaviour. 20 patients with a recent diagnosis of herpes attending either a specialist or general clinic were interviewed to determine patient satisfaction, and information provided on a number of key counselling topics identified by the BASHH herpes guidelines.
Results Provisional results from 79 patients demonstrate that those attending the specialist clinic were more likely to have complicating factors, including pregnancy, and psychological distress. Return to clinic with recurrences was 20% for the specialist and 15% for the general clinic. Full results will be available by the conference.
Discussion/conclusion Patients attending a specialist herpes clinic presented with more complicating factors, but despite this there was little difference between patient outcomes and satisfaction between clinics. Specialist herpes clinics may therefore be useful to manage more complex patients.

P179 EVALUATION OF AN ONLINE BOOKING SERVICE TO ACCESS ASYMPTOMATIC SCREENING

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10.1136/sextrans-2015-052126.222

Background/introduction Symptomatic patients are prepared to wait hours for open access sexual health services; however, patients without symptoms want simple and convenient access to testing.
Aim(s)/objectives We therefore introduced a new online booking service for asymptomatic patients and evaluated if patients would use it correctly.

Methods All booked asymptomatic screens from 1st December–13th January 2015 were analysed. These patients were registered and self-triaged as per normal and analysis of the electronic patient record was performed on the 27th January.
Results During this period 285 patients attended via the online booking service and the majority (91%) were asymptomatic and seen by the health care assistants. The median (min, max) number of appointment each weekday was 10 (1, 31) and 39% of these patients were from the local two boroughs.

Abstract P179 Table 1 Asymptomatic screens

Description	Male	Female	Total
Number	139 (49%)	146 (51%)	285 (100%)
Age in years, Median (range)	30 (21–58)	27 (18–47)	
Sexuality			
Heterosexual	106 (73%)	137 (99%)	243 (85%)
Bisexual	2 (1.4%)	1 (0.7%)	3 (1%)
Homosexual	37 (25%)	0	37 (13%)
Ethnic origin			
White	98 (67%)	100 (72%)	198 (70%)
BME	30 (21%)	25 (18%)	55 (19%)
Not stated	18 (12%)	14 (10%)	32 (11%)
Sexually transmitted infections			
Chlamydia	3 (2.1%)	5 (3.6%)	8 (2.8%)
Gonorrhoea	2 (1.4%)	2 (1.4%)	4 (1.4%)
Trichomonas vaginalis	0	1 (0.7%)	1 (0.4%)

Discussion/conclusion The majority of patients used the online booking service correctly. Further work is required to increase the range of services available via online booking.

P180 THE HOLY GRAIL, IS IT POSSIBLE? – A QUALITY IMPROVEMENT APPROACH USED TO INCREASE PRODUCTIVITY, CAPACITY AND OFFER A HIGH QUALITY AND TIMELY WALK-IN SEXUAL HEALTH SERVICE WITHIN EXISTING RESOURCE

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10.1136/sextrans-2015-052126.223

Background/introduction Patient feedback consistently informed us that they disliked waiting to be seen. Our Sexual health clinic (SHC) was facing challenges of low staff morale, uncertainty around future tendering arrangements and declining attendances. Quality improvement methods were used to empower the multidisciplinary team to find solutions for improvement and two priorities emerged, to see walk-in patients on time and to extend our evening clinic provision from two to four per week.
Aim(s)/objectives
Aims:

- To reduce the average waiting time for walk-in patients in a SHC by 50%.
- To see every walk-in patient within 20 min of the allocated slot time by April 2015.

Objectives:

- Increase productivity by 15%.
- Extend evening clinic provision within existing resource.
- Introduce asymptomatic quick check service.

Methods A quality improvement approach, using the Institute of Healthcare Improvement's model for improvement was used. The whole multidisciplinary team (MDT) met bi-monthly and ideas were tested using plan, do, study, act (PDSA) cycles. Measurement was introduced using statistical process control charts.
Results The quick check service shows a 40% increase in uptake, from 10 to 14 patients (average), (range 4–23). We introduced minimum patient allocated numbers, following these interventions there is a 42% reduction in average waiting times from allocated slot time (31 min pre and 18 min post intervention). Our productivity last month increased by 14%.
Discussion/conclusion A quality improvement approach was a successful method to improve the quality of our services, respond to patient feedback and effect change in a sexual health clinic.

P181 RETROSPECTIVE AND PROSPECTIVE ANALYSIS OF THE INPATIENT MANAGEMENT OF EPIDIDYMO-ORCHITIS

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10.1136/sextrans-2015-052126.224

Background/introduction Epididymo-orchitis, a common urological diagnosis in men aged 18–50, has significant sequelae if inadequately treated. Causative organisms in patients under the age of 35 are most commonly sexually transmitted infections. In patients over 35 enteric Gram-negative organisms causing urinary tract infections are more prevalent. Empiric treatment should be commenced as per guidelines until results of investigations are known.
Aim(s)/objectives To evaluate inpatient management of epididymo-orchitis.
Methods Data was retrospectively collected from June to December 2014 for all epididymo-orchitis patients diagnosed clinically. Information was obtained from notes, radiology and pathology databases. A 3 month prospective study is ongoing to improve investigations and antibiotic prescribing.
Results 7 of 26 inpatients diagnosed with epididymo-orchitis were under 35 years of age and 19 over 35. 19 were diagnosed with unilateral epididymo-orchitis and 7 bilateral. 4 patients developed abscesses, and 1 had an orchidectomy. 6 had a first-void urine, 14 a mid-stream urine, and 3 a urethral swab. 9 patients were discharged on doxycycline and ciprofloxacin, 7 with ciprofloxacin monotherapy. Duration of treatment as an outpatient ranged from 7 to 42 days.
Discussion/conclusion Current inpatient management of epididymo-orchitis varies significantly, and a third of patients are being discharged on doxycycline and ciprofloxacin, a combination not recommended in the BASHH guidelines. BASHH recommends cefuroxime +/- gentamicin for management of inpatients over 35 years of age; however in view of the risk of clostridium difficile this may require updating. This and our ongoing prospective study may provide results to help recommend appropriate antibiotics for inpatients with epididymo-orchitis.

Abstract P181 Table 1 Inpatient antibiotics for patients diagnosed with Epididymo-orchitis

Age	<16	<20	20–29	30–39	40–49	50–59	60–69	70–79	80–89
No of patients	3	1	1	4	7	4	3	2	1
Doxy				1					
Cipro	1			1	1				
Doxy/cipro				1	3	1		1	
Gent							1		
Gent/cipro							1		
Gent/Cipro									
Ceftriax				1					
Gent/cipro/Doxy						1			
Taz/Doxy	1							1	
Taz/Cipro						1			
Taz					1				
Taz/Flucon					1				
Augmentin		1			1		1		
Cephalexin						1			
Ceftriaxone/ doxy			1						
Ceftriaxone/ Cipro/doxy					1				
Doxy/Cipro/Mero									1

P182 CLINICAL CASE NOTE REVIEW: ARE ALL APPROPRIATE UNDER- 16S BEING TESTED FOR CHLAMYDIA AND GONORRHOEA?

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10.1136/sextrans-2015-052126.225

Background/introduction The number of young people under the age of 16 diagnosed with Chlamydia Trachomatis and Neisseria Gonorrhoea continues to rise annually. STI testing is essential to promote safe sexual practice, minimise stigma and monitor levels of anti-microbial resistance.

Aim(s)/objectives This project aimed to determine the percentage of under- 16s who were not tested for chlamydia and gonorrhoea between January and April 2013. The role of testing was established with aims including:

- Comparison of attendance, testing and infection rates of males and females.
- Analysis of documented reasons for not testing.
- Percentage of eligible patients not documented to have been offered a sexual health screen (SHS).

Methods 200 patients were randomly selected by attendance at sexual health clinics over a four month period. Information was then gathered on each consultation using NaSH software. Information gathered included gender, age at consultation, tests requested and clinic attended.

Results Results showed that 56% of patients were not tested for chlamydia and gonorrhoea; 6% were not documented as having been offered a SHS. Reasons for not testing are documented below in descending order of prevalence:

Reason	Untested population (%)
SHS up to date	37
SHS declined	18
SHS not indicated	14
First time sexual activity	12
Not sexually active	10
Too early for SHS	4

Discussion/conclusion The rate of failure to document the offer of a SHS is reassuringly low. Rates of attendance and infection were highest in females. Healthcare professionals should continue to encourage testing of the sexually active and ensure offers of SHS are documented.

P183 TRICHLOROACEITIC ACID (TCA) – A FORGOTTEN TREATMENT FOR GENITAL WARTS?

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10.1136/sextrans-2015-052126.226

Background/introduction Genital warts (GWs), are the most common STI in the UK. They can have a huge psychological impact on patients and can be very difficult to clear. There has been little research and few RCTs comparing treatments. In Glasgow, TCA is reserved for patients that standard treatments have failed.

Aim(s)/objectives To describe the use of TCA as a treatment for persistent and recurrent GWs and to review the local practice and protocol.

Methods We conducted a retrospective case review of all patients who received TCA in 2013 in our integrated sexual and reproductive health service with follow-up to the end of 2014. Patients were identified by prescriptions of TCA on our electronic patient record.

Results TCA was used on all types of warts in a variety of multiple locations. 20 out of 27 patients achieved clearance with TCA in 2013 (74%) and of these, 5 experienced recurrence in 2014 (25%). Patients with some level of immunosuppression may benefit from TCA treatment and respond earlier than those with a fully functioning immune system.

Discussion/conclusion TCA is an effective treatment for persistent and recurrent GWs; either used alone or with an adjuvant therapy, with relatively few side-effects. It can provide patients who have exhausted many/all other treatment options, positive results and improve mental well-being.

This audit also highlights the importance of improved documentation of warts by our staff and closer adherence to the existing clinic protocol for the management of GWs.

P184 EXPERIENCE OF THE TENDER PROCESS AND INTEGRATION OF SEXUAL HEALTH SERVICES: STAFF SURVEY

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10.1136/sextrans-2015-052126.227

Background/introduction In September 2013 four services merged to form a new integrated sexual health (ISH) service under a new NHS provider following a tender process.

Aim(s)/objectives To ascertain staff experience of the tender process and integration of sexual health services.

Methods All staff were asked to complete an online survey in 01/2015 (via SurveyMonkey®). Staff who did not transfer to the new NHS provider or who left the service before 01/2015 were not included.

Results 23/38 (61%) staff members (including medical, nursing, administrative and allied health professionals) responded. 5/23 (22%) were entirely/predominantly from a genitorurinary background and 9/23 (39%) entirely/predominantly contraception

background. 16/23 (70%) worked at one of the four previous services. Staff experience of the tender/integration process in terms of 'stress'/'excitement' levels are reported in the Table 1.

Abstract P184 Table 1 Staff survey

	Pre 09/2013 (%)	Months 0–6 (%)	Months 7–12 (%)	Month 12 onwards (%)
Moderate-Very Exciting	0 (0)	1 (5)	3 (15)	11 (50)
Mildly exciting	0 (0)	0 (0)	4 (20)	2 (9)
No different	4 (27)	0 (0)	2 (10)	0 (0)
Mildly stressful	3 (20)	2 (10)	3 (15)	4 (18)
Moderate-Very Stressful	9 (60)	17 (85)	13 (65)	7 (32)
Total respondents*	**15**	**20**	**20**	**22**

*Respondents were able to tick multiple answers

14/22 (64%) of staff believe that SH services should be integrated. 17/22 (77%) feel patients are now getting a better service (with further improvements needed).

Themes Main 'positives experienced': new skills gained, increasing integration/offer of a 'one-stop-shop' service. Main 'challenges experienced': resistance to change, clash of specialty 'cultures'. The predominant 'suggestion for improvement' was better communication with all staff throughout the process.

Discussion/conclusion The experience of the tender process and early months in the new ISH service was stressful for many staff. This improved with time and staff reported feeling increasingly excited about the new service. Better communication from commissioners and service providers to all staff involved may improve the overall experience of those going through the process in the future.

P185 USING THE STIF PORTFOLIO IN AN "INTEGRATION" TRAINING STRATEGY

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10.1136/sextrans-2015-052126.228

Background Many UK sexual health clinics are in the process of integrating Sexual and Reproductive Health (SRH) and GUMedicine (GUM) services. Amongst the many challenges they face is that of appropriately training newly integrated staff. Our unit is has recently undergone integration of contraception, termination, outreach and GUM/HIV services. Central to this process was the establishment of a comprehensive training strategy for all clinical staff.

Objectives To describe the successful implementation of an integration training strategy using BASHH's STIF portfolio between 2012–2014.

Methods An initial baseline staff survey demonstrated a lack of consistency of formal sexual health qualifications amongst both SRH and GUM staff. It also highlighted considerable skills amongst some HCAs who had lacked opportunity to formalise them. Our desire was to use existing national qualifications and provide equality of access to all grades of staff.

Results Between 2012–2014 we ran 2 STIF theory courses and 4 STIF*Level 1* assessments. In total 53 staff attended STIF theory and 45 successfully completed STIF*Level 1* (including 8 HCAs). A further 7 senior nurses and 2 SRH doctors have completed STIF*Intermediate*. One band 7 GUM nurse has also completed STIF*Advanced*.

Conclusion The STIF portfolio has provided practical and effective tools in training and assessing staff during our local integration process. We believe that the existence of a clear training strategy helped maintain moral and staff retention during a potentially difficult time and the high level of national qualification amongst our staff will hopefully stand us in good stead in the current commissioning climate.

P186.1 DOES CHLAMYDIA TESTING IN GENERAL PRACTICE MEAN MISSED OPPORTUNITIES FOR THE DIAGNOSIS OF OTHER STIs?: A COMPARISON OF THE POPULATION TESTED IN GENERAL PRACTICE VERSUS SEXUAL HEALTH CLINICS IN BRITAIN

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10.1136/sextrans-2015-052126.229

Background Chlamydia testing in general practice may provide opportunities to diagnose those who do not attend sexual health (GUM) clinics. However, as comprehensive STI testing is less likely to be offered in general practice, opportunities could be missed to test, diagnose and treat other STIs including HIV if people at higher sexual risk test in general practice.

Aim To compare demographic, behavioural, and HIV testing characteristics of those tested for chlamydia in general practice with those tested in GUM.

Methods A probability sample survey of the British population undertaken 2010–2012. We analysed weighted data on individuals aged 16–44, reporting at least one sexual partner ever, who reported a chlamydia test in the past year (n = 1583).

Results 26.0% (24.7–27.4) of women and 16.1% (14.9–17.3) of men reported testing for chlamydia in the past year, of whom 41.4% (38.6–44.2) of women and 20.5% (17.4–24.0) of men tested in general practice. Women tested in general practice were more likely to be older, in a relationship, and to live in rural areas. Men and women tested in general practice reported lower STI risk in terms of (past 5 years): partner numbers, same-sex partners, and overlapping partnerships. Those tested in general practice were less likely to report an HIV test (past 5 years).

Discussion/conclusion While those tested for chlamydia in general practice generally reported lower risk behaviours, rural populations were over-represented, and HIV testing was lower. Pathways to comprehensive STI care need to be universally available for higher risk individuals.

P186 HIGH LEVELS OF USE OF RECREATIONAL DRUGS AND ALCOHOL WITHIN AN INNER LONDON SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.230

Background Drug and alcohol use by patients attending sexual health clinics is not widely assessed as routine. BASHH history taking guidelines and position statement on recreational drug use

Abstract P186 Table 1 Recreational drug use

N (%)	Cocaine	Ecstasy	Ketamine	Meph	GBL/GHB	Crystal Meth	Poppers	Nitrous Oxide	Cannabis	Where help would be preferably be sought N = (15)
MSM (n = 20)	12 (63)	7 (37)	6 (32)	11 (58)	8 (42)	4 (21)	8 (42)	3 (16)	8 (42)	GUM Clinic 6 (32)
WSM (n = 19)	70 (14)	6 (30)	3 (15)	3 (15)	2 (10)	2 (10)	5 (25)	4 (20)	1 (5)	GUM Clinic 8(50)
Het Men (n = 3)	1 (33)	1 (33)	1 (33)						1 (33)	GP 1 (33) or Drug Clinic 1 (33)

recommend obtaining such histories, enabling identification of patients at risk and refer appropriately.

Aim To identify drug and alcohol use among GU patients attending a routine clinic appointment.

Methods Anonymous questionnaires were offered to all patients over a five day period. Drug and alcohol use over past 6 months, whether it was patient-identified as problematic and where help would be sought were obtained

Results Of the 116 respondents, with an average age of 30 years, there were 61 (52%) women, 30 (26%) MSM and 25 (22%) heterosexual men. Of these 60 (52%) disclosed drug use and 105 (81%) disclosed drinking alcohol; 4 respondents were concerned about their drug use and 48 (49%) reported high alcohol intake.

Conclusion There is a high level of drug and high alcohol use by a significant number of patients of all genders and ages. However it is self-deemed as problematic by only a small proportion. More routinely collected data is required to fully understand this and the potential impact it may have on sexual health.

Category: Miscellaneous

P187 A PHASE 1 STUDY TO ASSESS THE SAFETY, TOLERABILITY AND PHARMACOKINETIC PROFILE OF BOCEPREVIR AND SILDENAFIL WHEN DOSED SEPARATELY AND TOGETHER, IN HEALTHY MALE VOLUNTEERS

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10.1136/sextrans-2015-052126.231

Background/introduction Boceprevir is a first generation direct-acting antiviral (DAA) licensed for the treatment of hepatitis C infection. Sildenafil is an oral therapy for erectile dysfunction. As boceprevir is a potent inhibitor of CYP3A4, potential pharmacokinetic interactions may occur when co-administered with sildenafil.

Aim(s)/objectives The aim of this study was to assess the pharmacokinetic profile of sildenafil and boceprevir when dosed separately and together in healthy volunteers.

Methods Thirteen male subjects completed the following study procedures: phase 1 (day 0), single dose sildenafil 25 mg was administered; phase 2 (days 1–9), washout period; phase 3 (days 10–15), boceprevir 800 mg three times a day was administered; phase 4 (day 16), boceprevir 800 mg and sildenafil 25 mg were administered. All drugs were administered in a fed-state. Intensive pharmacokinetic sampling was undertaken on days 0, 15 and 16. Differences in pharmacokinetic parameters of sildenafil, N-desmethyl-sildenafil and boceprevir between phase 4 and earlier phases were evaluated by changes of geometric mean ratios (GMR).

Results All drugs were well tolerated with no safety concerns arising. In the presence of boceprevir (phase 4 versus phase 1), sildenafil GMR maximum plasma concentration (Cmax) and area-under-the-concentration-time-curve (AUC_{24}) increased by 1.9 fold (95% CI: 1.5–2.4) and 2.7 fold (95% CI: 2.1–3.4), respectively whereas a reduction in N-desmethyl-sildenafil Cmax was observed (GMR 0.5, 95% CI: 0.4–0.7). No significant changes in boceprevir exposure were observed between phases 4 and 3.

Discussion/conclusion Sildenafil exposure is increased in the presence of boceprevir. Dose adjustment of sildenafil is necessary. An initial dose of 25 mg of sildenafil is suggested.

P188 'FIND YOUR MATE'! AN INTERACTIVE GAME TO SUPPORT THE TEACHING OF SEXUAL HISTORY TAKING TO MEDICAL STUDENTS

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10.1136/sextrans-2015-052126.232

Background/introduction Standard methods of teaching sexual history taking are heavily reliant on role-play which many students find threatening. We took a fresh look at this with particular reference to the learning environment and learner diversity.

Aim(s)/objectives To develop a new resource as an alternative to role-play which allows students to practice the key components of sexual history taking in a fun and memorable way.

Methods The concept of 'find your mate' grew through brainstorming sessions with a medical student and an F2 trainee. The idea of a 'party atmosphere' with background music allows those with 'musical intelligence' to create a link whilst also masking individual conversations and reducing embarrassment. Provision of party snacks and soft drinks addresses players' basic physiological needs.

Results An interactive game was developed with flexibility to accommodate any number of participants from 6–30. Feedback was universally positive with players reporting marked improvement in confidence scores in sexual history taking.

Discussion/conclusion Students often find terminology used in sexual history taking unfamiliar or uncomfortable. They come from a variety of social, ethnic and religious backgrounds and may carry judgmental attitudes. Some may have had negative sexual experiences. Providing a psychologically and physically safe environment for them to develop this important skill is of

paramount importance. I am confident that giving students a framework of standard questions and phrases and then allowing them the combined privacy and space to practice the use of such in a safe learning environment will improve their confidence in sexual history taking.

P189 "... GIVING SOMETHING BACK TO THE GAY COMMUNITY BY TAKING PART": GAY AND BISEXUAL MEN'S UNDERSTANDINGS OF PARTICIPATION IN BEHAVIOURAL RESEARCH

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10.1136/sextrans-2015-052126.233

Background/introduction Studies exploring public participation in health research have not, to date, included the perspectives of gay and bisexual men taking part in behavioural surveillance research. Understanding factors which motivate men to participate in behavioural research, and their perceptions of feedback on anonymous HIV antibody tests are important in the design of future studies.
Aim(s)/objectives The aim of this qualitative study was to gain insight into men's motivations for participation in the Gay Men's Sexual Health Survey (GMSHS), and their understandings of, and views on, HIV testing as part of the survey.
Methods Semi-structured telephone interviews were conducted with 29 gay and bisexual men who participated in the 2011 GMSHS. Men were recruited in 13 licensed premises on the commercial 'gay scene' in Edinburgh and Glasgow. Data were analysed thematically, focusing on motives for participation and perceptions of not receiving individual feedback on HIV status.
Results Most men expressed sophisticated understandings of the purpose of behavioural research and distinguished between this and individual diagnostic testing for HIV. Men's accounts suggested a shared understanding of participation in research as a means of contributing to 'community' HIV prevention efforts. Among the men interviewed feedback on HIV status was not deemed crucial.
Discussion/conclusion Continuing to engage with gay and bisexual men, and practitioners working within these communities, is vital to engendering trust in, and support for, future behavioural research. This is particularly important during the process of developing new and innovative research strategies. Further research is needed to explore men's perceptions of participation in research, and their perspectives on receiving feedback on testing, within wider contexts.

P190 WE DON'T NEED NO SEX EDUCATION: DO YOUNG PEOPLE VALUE THE KNOWLEDGE THEY GAIN FROM SCHOOL AND SEXUAL HEALTH SERVICES?

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10.1136/sextrans-2015-052126.234

Introduction There remains ongoing debate regarding the value of sex education in schools and if today's young people subsequently rely on alternative resources to learn about sex and relationships.
Aims As a provider of sexual health services for young people aged under 25 we wanted to establish if there was an expectation amongst service users for us to provide sex education.
Methods Questionnaires were distributed to all service users between April and September 2014. Questions were designed to assess how sexual knowledge had been acquired, and which method of knowledge acquisition was most valued.
Results 179 service users completed questionnaires. 160 were female, 149 were heterosexual. Median age was 18.6 years.

177 (98.9%) reported receiving sex education at school which predominantly covered reproduction and contraception. Comparing methods of knowledge acquisition advice from friends was the most valued (84, 46.9%), followed by sexual partners (57, 31.8%) and family (56, 31.3%). Formal sex education was only valued by 34 (19.0%), with sexual health clinic advice valued by 32 (17.9%).

The desire for more sex education at school was mixed with 74 (41.3%) wanting more and 106 (59.2%) requesting no change or were unsure. 46 (25.7%) requested an increase in education from our clinic.
Conclusion Service users valued knowledge gained from peers and family over current methods of formal sex education with no significant desire to increase current educational provision. Sexual health services should engage young people in discussions regarding this peer-based learning to reinforce good sexual health and dispel inevitable myths.

P191 SURVEY OF GENITAL DERMATOLOGY TRAINING AMONGST GENITOURINARY MEDICINE (GUM) SPECIALIST REGISTRARS

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10.1136/sextrans-2015-052126.235

Introduction There has been no recent review of genital dermatology (GD) training for GUM trainees. The 2010 GUM specialist registrar curriculum states specific learning objectives that trainees should meet by CCT.
Aim In order to evaluate and improve training, the BASHH GD Special Interest Group (SIG) conducted an online survey to assess specialist registrar training in GD.
Methods The survey was designed through Survey Monkey and cascaded to trainees across the UK in 2014.
Results 42 trainees responded, representing several deaneries (50% London) and grades. 68% of trainees receive GD training through adhoc clinical teaching; 85% through formal lectures. 26%, 32%, 37% have attended specialist GD clincs by gynaecologist, GUM physician, dermatologist respectively. Mean confidence in managing specific conditions varied from 5 (vulval pain syndromes) to 7.5 (fungal infections) (1–10 confidence scale). 47% were 7/10 confident in topical steriod use (1–10 confidence scale). Independently able to perform procedures: 21% punch biopsies, 63% fungal scrapings, 15% curettage.

50% of trainees are satisfied with GD training with 69% feeling they will be adequately trained by CCT. 58% would like a formal qualification in GD to be available.
Discussion Training in GD is variable with mixed confidence in diagnosis, treatment and practical procedures. Many trainees feel

training could be improved with requests for a formalised attachment, formal qualification and greater training in practical procedures.

The BASHH GD SIG, in liaison with BASHH, aims to optimise GD training for registrars. Plans for improved resources are in progress, including a practical skills course and e-learning.

P192 SUDDENLY YOU'RE ON YOUR OWN, AND YOU'RE OUT THERE IN THE BIG WORLD: MIDDLE-AGED ADULTS' SEXUAL RISK-TAKING BEHAVIOURS WITHIN THE CONTEXT OF LIFE-COURSE TRANSITIONS

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10.1136/sextrans-2015-052126.236

Background/introduction While sexual activity, including partner change, is known to continue throughout the life course, there is a paucity of qualitative evidence on how adults over 45 years engage with risk for sexually transmitted infections (STIs), limiting the scope for effective health promotion among this age group.

Aims/objectives The research aimed to explore older adults' sexual risk-taking behaviour within the context of sexuality in later life.

Methods A qualitative in-depth study involving 31 interviews with middle aged heterosexual men and women aged 45 to 65, recruited from sexual health clinic and community settings.

Results Vulnerability to STI risk emerged around key life course transitions, including following divorce, separation and bereavement. Some spoke enthusiastically of embracing sexual freedom and pleasure within a perceived changed culture, resulting in frequent partner change; however, many found themselves 're-engaging' with their sexual careers within an unfamiliar gendered landscape. Lacking an (ageing) body confidence led to the prioritisation of intimacy over STI risk; condoms were viewed as being for birth control and therefore mostly unnecessary, or linked with casual sex and lack of trust. STIs were commonly considered to be a young person's concern.

Discussion/conclusions Information provision alone will not be enough to counter the complexities of navigating the dramatically different sexual landscape these older adults find themselves within compared to their youth, particularly those who have emerged from long-term relationships. A separately focussed approach to STI prevention taking account of life course experience, ageing and cultural change is advocated.

P193 DEVELOPMENT OF A HANDHELD POINT OF CARE MOLECULAR DIAGNOSTIC DEVICE FOR SEXUALLY TRANSMITTED INFECTIONS

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10.1136/sextrans-2015-052126.237

Background/introduction Brunel DoCLab is part of the *e*STI2 Consortium which is developing electronic self-testing and portable instruments for sexually transmitted infections using nucleic acid amplification test technologies. We have designed a point of care test platform that integrates a proprietary sample collection device directly with a microfluidic cartridge. A low cost benchtop real-time isothermal amplification platform has been developed capable of running six amplifications simultaneously.

Aim(s)/objectives To evaluate the sample preparation and isothermal amplification within the low cost diagnostic platform.

Methods The microfluidic device incorporates passive mixing of the lysis-binding buffers and sample. Cell lysis, within the cartridge, is conducted using a chemical method and nucleic acid purification is done on an activated cellulose membrane. Isothermal amplification was conducted using recombinase polymerase amplification (RPA).

Results Preliminary results have shown extraction efficiencies for this new membrane of 69% and 57% compared to the commercial Qiagen extraction method of 85% and 59.4% for 0.1 ng/μL and 100 ng/μL salmon sperm DNA respectively spiked in phosphate buffered solution. Extraction experiments in the passive mixer cartridges with lysis and nucleic acid purification showed extraction efficiency around 80% of the commercial Qiagen kit. The platform is capable of detecting *Chlamydia trachomatis* genomic DNA within 10 min using RPA for 100,000 copies/μL.

Discussion/conclusion The work presented here shows a low cost, rapid nucleic acid extraction, isothermal amplification and detection platform for diagnosing C. trachomatis. Work is ongoing to fully integrate the sample-in to result platform for rapid diagnosis of STIs using genital samples.

P194 COST-EFFECTIVENESS OF CHLAMYDIA TESTING IN SCOTLAND

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10.1136/sextrans-2015-052126.238

Background/introduction Scottish chlamydia testing guidelines target symptomatic and high-risk asymptomatic individuals. Recent publications, indicating a low risk of progression to serious chlamydia-related outcomes, particularly tubal factor infertility (TFI), question the validity of high levels of opportunistic testing especially among asymptomatic individuals.

Aim(s)/objectives To examine cost-effectiveness of current chlamydia testing to prevent TFI among those aged 15–24 in Scotland using cost per Quality-Adjusted Life Years (QALYs) gained and to consider alternative testing strategies.

Methods A compartmental deterministic model of chlamydia infection in those aged 15–24 in Scotland was developed to examine the impact of testing coverage and partner notification (PN) on number and cost of TFI cases prevented. Cost-effectiveness calculations were informed by best estimates of the QALYs lost due to TFI.

Results At 16.8% baseline testing coverage (laboratory data), 4.4% prevalence (NATSAL-3) and assumed PN rate of 0.4, the total testing cost is £5.4 million. This is estimated to prevent 258 TFI cases each year in young women. The cost per QALY gained is £40,034 compared with no testing, using a mid-range health state utility value (HSUV) for TFI (0.76 ($\pm$0.24)) and PID (0.9 ($\pm$0.22)). A 50% reduction in current testing would result in higher chlamydia prevalence and 84 more TFI cases.

Discussion/conclusion Current chlamydia testing activities in Scotland do not appear cost-effective. However, the model is sensitive to several parameters, particularly the HSUV and there are uncertainties in the current testing costs and progression to

serious sequelae. There appears potential to improve chlamydia testing cost-effectiveness by increasing PN.

P195 SHOULD MALE CIRCUMCISION BE CONSIDERED CURATIVE TREATMENT FOR LICHEN SCLEROSUS?

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10.1136/sextrans-2015-052126.239

Lichen Sclerosus is a chronic inflammatory skin disorder. In men it presents mainly on the prepuce, coronal sulcus and glans penis. The cause of lichen sclerosus is not fully understood, but genetic and autoimmune factors are thought to be important. Infections have been investigated as a cause, but with no clear evidence of a potential causative agent. In men the association with autoimmune diseases is weaker; however studies have shown a family history of diabetes mellitus, and thyroid disease are possible risk factors. Other suggested potential causes are chronic intermittent damage by urine, as early circumcision seems to be preventative in those who do not have congenital anomalies such as hypospadias.

Recommended treatments include circumcision and potent topical steroid ointments. Taking this into consideration we reviewed notes of patients that presented to the monthly Joint Dermatology clinic with a diagnosis of lichen sclerosus to ascertain the number of recurrences post circumcision.

We found four cases of recurrence of lichen sclerosus in patients attending the clinic over a four month period. Ages varied between 39–81 years old. One patient had diabetes mellitus, and another had been circumcised twice. All patients needed treatment with potent topical steroid ointment. Lipscombe *et al*. stated that 50% of patients who had a circumcision had a recurrence. It is important when discussing management with patients to remember that lichen sclerosus can recur after circumcision. From our observations, the presence of folds of skin still covering the glans penis best predicts recurrence.

P196 VULNERABILITY FACTORS IN VICTIMS OF SEXUAL ASSAULT PRESENTING TO A RURAL SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.240

Background/introduction The Office for National Statistics show that 1/5 of women and 1/40 men over 16 years report having been a victim of sexual assault (SA).

Aim(s)/objectives To identify vulnerability factors (VFs) including alcohol/substance misuse and mental health conditions, in patients presenting as a direct result of a SA or who disclose a previous SA during a routine consultation.

Methods Retrospective notes review of 2 patient groups to identify VF disclosure;

1. All new presentations during a 2 week period disclosing previous SA during their consultation.
2. All presentations to sexual health over a 3 month period directly related to a SA.

Results Group 1: 291 attendances. 19 (6.5%) (16 female, 3 male) disclosed previous a SA, 3 were <18 yrs.

Group 2: 34 attendances (32 females, 2 males) aged 13–61 years (8 were <18 years). Those with VFs are shown in the table below.

Abstract P196 Table 1 Vulnerability factors for sexual assault

	Number of Patients (%)	
Vulnerability Factors (VF)	**Group 1**	**Group 2**
High Alcohol Intake	5 (26)	10 (29)
Recreational Drug Use	5 (26)	5 (15)
Previous Sexual Assault	n/a	11 (32)
Previous Domestic Violence	Not Available	5 (15)
Known to Social Services	3 (16)	12 (35)
Looked after Child	2 (11)	2 (6)
Vulnerable Adult	3 (16)	6 (18)
Mental Health Condition	7 (37)	20 (59)
Patients with 2 or more VFs	10 (53)	18 (53)

Discussion/conclusion Over 50% of patients had 2 or more identifiable VFs. Increasing staff awareness of VFs and improving links with support services may help to reduce the risk of sexual assault in vulnerable groups by allowing earlier identification of those at risk.

P197 DOWN WITH THE KIDS – ARE WE DOING ENOUGH TO PROVIDE A HOLISTIC SEXUAL HEALTH SERVICE TO VULNERABLE YOUNG PEOPLE?

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10.1136/sextrans-2015-052126.241

Background/introduction The sexual health of young people in the UK is amongst the worst in Europe, with high prevalence of sexually transmitted infections (STIs) and unwanted pregnancies. Although most are involved in consensual sexual activity, they may also be victims of sexual abuse or exploitation, usually unrecognised by themselves or health care professionals.

We have developed a proforma based on the BASHH young persons' proforma for patients under 18 attending the service which includes safe guarding issues.

Aim(s)/objectives To review the management of young persons' sexual health in an inner city sexual health clinic.

Methods Retrospective case note review of all patients <18 years attending clinic in 2012 and 2013.

Results 93 patients were identified; 34 (36.6%) were <16 years (7 M; 27F); median age 15 years (range 11–15). 32 (94.1%) were sexually active; all (100%) of which accepted STI screening. 14 (45.2%) tested positive for at least one STI. The proforma was completed for 33 (97.1%) patients.

14 (41.2%) of the patients had contact with social services; 10 (29.4%) had non-consensual sexual activity; 15 (44.1%) had mental health issues and 4 (11.8%) used recreational drugs. All of them have been followed up according to local guidelines.

Conclusion The proforma enables us to identify those with safeguarding issues and STIs. An appropriate safeguarding referral pathway and local multi-agency arrangements are in place to help and protect these young people. Further education and communication are needed to raise the awareness and improve the sexual health and wellbeing of the young people.

P198 DOES GUM SPECIALITY TRAINING PREPARE NEW CONSULTANTS TO MANAGE SEXUAL DYSFUNCTION?

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10.1136/sextrans-2015-052126.242

Background/introduction Service provision for patients with sexual dysfunction (SD) in the UK varies according to locality and available expertise. Speciality training in SD may be variable and poorly standardised.

The 2010 GUM curriculum is due for review in 2015. The opinion of senior trainees and new consultants will help inform these curriculum developments.

Aim(s)/objectives We aim to establish

- whether new consultants feel adequately equipped to manage patients with SD
- what additional training is currently being undertaken
- whether additional training opportunities would be welcome

Methods An electronic survey was distributed to 51 trainees within 24 months of CCT and 19 new consultants.

Results The response rate was 39% (27/70) from 9 deaneries. 92% (24/26) felt that having training in SD as a GUM physician was important (46%) or very important (46%). Most trainees had had some exposure to informal teaching 89% (24/27) or departmental teaching 63% (17/27) but very few had formal training. Only 8% (2/26) of respondents felt their training had adequately equipped them to manage SD. 46% (12/26) felt equipped to some extent but 31% (8/26) did not feel adequately equipped to manage SD. 88% (23/26) felt they would benefit from further training.

Discussion/conclusion Many senior trainees and new consultants do not feel equipped to manage SD. The ability to recognise and appropriately refer patients with SD is essential for any GUM clinician. The 2015 curriculum review will help standardise core training in SD, as well as providing opportunities for those who wish to deliver specialised services in future.

P199 CHANGING TEENAGERS' PERSPECTIVES ON THEIR SEXUAL HEALTH: RESULTS FROM AN INNOVATIVE EDUCATIONAL PROGRAMME IN UK SECONDARY SCHOOLS

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10.1136/sextrans-2015-052126.243

Background/introduction UK schools are not obliged to provide comprehensive sex and relationships education (SRE). SRE is frequently outdated, taught by non-specialists, and covers only the technicalities of heterosexual sex and sexually-transmitted diseases.

Aim(s)/objectives We aimed to deliver a peer-led programme of age-appropriate sessions covering sexual, physical, and psychological health, inclusive of non-heterosexual and non-cisgender identities. Sessions were designed to empower young people aged 11–18 to discuss these topics in a non-judgemental environment.

Methods 50-minute sessions encompassed body image, drugs and alcohol, sex and sexual risk taking, or contraception. Trained university student volunteers employed games, small group discussions, quizzes, and visual media. Volunteer to pupil ratio averaged 1:8. Pupils were encouraged to ask questions and reflect throughout. Anonymous written feedback assessed pupils' enjoyment of the sessions, volunteers' teaching ability, and impact of the sessions on their self-perception.

Results 876 feedback forms were completed. 91.8% of pupils enjoyed the sessions and 93.0% rated them as well taught. 61.9% of pupils reported the session to have changed the way they felt about themselves or their health. Free text comments from the remaining 38.1% indicated prior comfort with navigating health issues. Forms also showed high levels of satisfaction with the opportunity to receive non-judgemental, comprehensive responses from relatable peer-educators.

Discussion/conclusion Comprehensive SRE delivered by knowledgeable peer-educators allows teenagers to freely discuss issues surrounding their sexual and mental health, empowering them to make informed decisions and potentially affecting their risk-taking behaviours. This programme demonstrates an innovative but easily replicable means of providing this education.

P200 A FACILITY TO ENABLE HIGH-QUALITY, TIME-EFFICIENT EVALUATIONS OF DIAGNOSTICS FOR STIs

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10.1136/sextrans-2015-052126.244

Background/introduction Control of STIs is challenged by inadequate access to prompt diagnosis and treatment for patients and partners. Novel point-of-care diagnostics have real potential to address some of these challenges but their robust evaluation, and hence utility, is hampered by the ethics and regulatory landscape that confronts industry and academia.

Aim(s)/objectives To develop a diagnostics and clinical facility to deliver high-quality, time-efficient diagnostic evaluations for STIs.

Methods A multi-institutional and disciplinary group (*e*STI[2]) including clinical, public health and social scientists, microbiologists, clinicians, trial coordinators, and North American and European regulatory expertise was established. An 'overarching' ethics, favourable costing, and regulatory framework was carefully developed and put in place to enable any new diagnostic evaluation involving residual and/or additional-to-routine patient-consented samples to start promptly without requiring lengthy ethics applications. Strong working relationships with *multiple* GUM clinics were developed to overcome the potential for clinic fatigue, and Good Clinical Laboratory Practice Standard Operating Procedures were enabled.

Results Since February 2012, the network has conducted several evaluations with both academia and industry, spanning initial 'proof of concept' projects using residual samples, multi-site diagnostic evaluations involving >800 additional-to-routine patient samples completed in four months, and service evaluations of CE-marked assays. A diagnostic evaluation to support an application for regulatory approval will be taking place in 2015.

Discussion/conclusion The development of a diagnostic facility for STIs that fast-tracks high quality diagnostic evaluations is

feasible and has potential for supporting promising diagnostic technologies towards NHS adoption.

P201 TENDERING OF SEXUAL HEALTH SERVICES: A REGIONAL STAFF SURVEY OF IMPACT ON CLINICS AND INDIVIDUALS

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10.1136/sextrans-2015-052126.245

Background The Health and Social Care Act was implemented in April 2013 and has led to tendering of Sexual Health (SH) services in England. By 2014 all of the services in our region had experienced tendering.
Aim To assess the impact of tendering on staff.
Methods Clinical leads within the region were asked to circulate an online survey to all clinical staff within the service. Details on job role, timing of tendering, results of tendering and how strongly individuals agreed or disagreed with statements about tendering were asked for.
Results There were 54 responses from individuals working within 7 services. 9 (17%) agreed with the statement "my physical health has been adversely affected". 34 (63%) disagreed with the statement "the process of tendering has not affected my psychological wellbeing". 39(73%) agreed with "the process of tendering has affected my enjoyment of my work". 25(47%) had considered leaving sexual health as a result of the tender. 24 (45%) agreed with the statement that they knew colleagues who had left SH as a direct result of tendering. 31(57%) agreed with the statement that their colleagues had seen less patients as result of tendering. 25(47%) disagreed with the statement "the tender has impacted negatively on how easily patients can be seen in our service".
Conclusion This is the first survey of staff experiencing tendering and demonstrates the physical and psychological impact on them. It is important to note the potential consequences of tendering on the stability of services as trained staff seek employment elsewhere.

P202 EVALUATION OF INTERFERING SUBSTANCES COMMON TO SWAB AND URINE SPECIMEN USING THE BD MAX™ CT/GC AND CT/GC/TV ASSAYS, A NEW AUTOMATED MOLECULAR ASSAY

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10.1136/sextrans-2015-052126.246

Background/introduction The BD MAX™ CT/GC and CT/GC/TV assays performed on the BD MAX™ System are qualitative multiplex assays designed for the detection of *Chlamydia trachomatis* (CT), Neisseria gonorrhoeae (GC), and Trichomonas vaginalis (TV) DNA in female urine, endocervical, and vaginal specimens, or CT and GC DNA in male urine specimens.
Aim(s)/objectives This study evaluated the performance of the BD MAX™ CT/GC and CT/GC/TV assays in the presence of interfering substances commonly found in vaginal swab and urine specimen.
Methods Vaginal and Urine specimen pool suspensions prepared in BD MAX™ UVE Sample Buffer were inoculated with (44) different biological, chemical, and bacterial substances at a concentration that may be found in urogenital specimens. Suspensions containing interfering substances were subsequently triple-spiked with quantitated cultures of CT, GC, and TV at 2X the Limit of Detection (LOD) for positive specimen. Negative specimens were not spiked with organism. All pools were inoculated into BD MAX™ UVE Sample Buffer Tubes, heated on the BD MAX™ Pre-warm Heater and tested on the BD MAX™ System.

Interference was determined as non-conforming positive or negative test results.
Results Interference was not identified with any of the 31 substances tested for urine. No interference was observed in vaginal swab specimens with the exception of contraceptive foams and gels (>25 μL/mL), metronidazole cream (>2.5 μL/mL) and whole blood (>0.66 μL/mL).
Discussion/conclusion These results demonstrate that the BD MAX™CT/GC and CT/GC/TV assays detect the presence of Neisseria gonorrhoea, *Trichomonas vaginalis*, and *Chlamydia trachomatis* in in the presence of interfering substances common in urine and vaginal swab specimen.

P203 CURRICULUM COMPETENCES-BASED EVALUATION OF GENITOURINARY MEDICINE HIGHER SPECIALIST TRAINING IN A LARGE TEACHING HOSPITAL

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10.1136/sextrans-2015-052126.247

Background/introduction Award of a certificate of completion of training is dependent on registrars attaining 44 competences described in the 2010 Genitourinary Medicine Higher Specialty Training curriculum.
Aim(s)/objectives This study evaluates clinical opportunities of a 4-year modular training programme in a large teaching hospital to determine:

1. Whether opportunity cost of training to service delivery is justifiable.
2. Competences that are inadequately addressed by direct clinical opportunities alone.

Methods Curriculum competences-based evaluation was undertaken with local faculty and trainees quantitatively assessing the 'usefulness' of the modular programme to meet each curriculum competence.

A Quality-Cost Justification matrix determined whether opportunity costs to service provision could be justified for individual clinical opportunities. This considered whether the opportunity is a mandatory curriculum requirement as well as the quality of training determined by triangulating quantitative 'usefulness' ratings of the faculty with qualitative findings of the trainee survey.
Results While 100% (n = 6) of registrars were either satisfied or very satisfied with existing clinical opportunities, these were only sufficiently useful for attaining 23/44 competences. Additional formalised training by way of an academic programme, opportunities to design teaching programmes and research and management experience were required to meet 10/20 GUM, 5/18 HIV, 6/6 management competences.

For all sexual health and 2/6 HIV clinical opportunities, the high quality of training justified the opportunity cost to service provision.

Discussion/conclusion The curriculum competences-based approach to training evaluation offers a focused and objective approach to resolve conflict of training and service provision. Furthermore, it highlights and supports formalisation of non-clinical training opportunities.

P204 SEX UNDRESSED: DEVELOPING A WEBSITE FOR YOUNG PEOPLE AROUND SEX AND BODY IMAGE

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10.1136/sextrans-2015-052126.248

Introduction Evidence shows that children and young people (CYP) have inter-related issues around self-esteem, body image, sex and relationships. Access to pornography and paucity of sex and relationship education in the UK is exacerbating this problem.

We want to develop an online resource for CYP addressing sex and body image, centred around videos from 'peer educators' but also containing information and links to other resources.

Aims To undertake a consultation period with the aim of informing the content and aims of the website.

Methods Workshops comprising: 1. Introduction of website concept. 2. Card-cluster participatory exercise, 'what I wish I had known when I was younger'. 3. Feedback.

Results 3 workshops were held, (participants = 19, M11, F8, age 20–30).

The concept was well-received and most participants wished to be involved. Concerns were expressed about people's willingness to speak openly about intimate issues in videos and potential for cultural bias in participation.

Card-cluster themes included rejecting the portrayal of sex in pornography, rejecting the portrayal of body image in the media, normalising masturbation, normalising body hair and concepts of consent and the right to enjoy sex.

70% felt clear about the project, and 100% felt included.

Conclusion Our findings indicate strikingly similar concerns and insecurities that could be amenable to positive role models and educational resources in a youth-friendly website. We recognise the need to engage diverse groups (in terms of race, class, sexuality) to encourage inclusive content and users.

Category: STIs in special groups

P205 RETESTING FOR GENITAL CHLAMYDIA INFECTIONS IN YOUNG PEOPLE IS ACCEPTABLE AND IMPORTANT

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10.1136/sextrans-2015-052126.249

Background/introduction Young persons with a previous history of genital chlamydia are more likely to retest positive at a later date than those that have never tested positive. Current recommendations advise offering a repeat NAAT test to individuals under the age of 25, three months after completing treatment. However, a recall system has yet to be implemented in our clinic.

Objectives We examined how many young people treated for genital chlamydia voluntarily returned for a further test, to assess whether asymptomatic retesting is both acceptable and worthwhile in this group. We aimed to identify a suitable timeframe in which retesting should be offered.

Methods Retrospective case note review of individuals under 25 years who tested positive for genital chlamydia in a city wide sexual health service in January 2013.

Results Of 214 individuals testing positive for genital chlamydia in January 2013, 50% (107/214) retested within 15 months, 29% of which were positive (31/214). Most young people returned 3 to 6 months following their initial diagnosis (37/107), but the highest number of positive results occurred between 7 and 9 months (10/31). Only 8 individuals (7.5%) were retested between 10 and 12 months, though a significant proportion (25%) retested positive.

Conclusion The high rate of young people returning for chlamydia retesting after a positive diagnosis indicates that retesting is acceptable within this group. The high rate of subsequent positive tests suggests that retesting is important and worthwhile. The ideal timeframe to retest these individuals is 3–12 months following a positive test.

P206 SEXUAL HEALTH RISKS, SERVICE USE, AND VIEWS OF RAPID POINT-OF-CARE TESTING AMONG MEN-WHO-HAVE-SEX-WITH-MEN ATTENDING SAUNAS: A CROSS SECTIONAL SURVEY

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10.1136/sextrans-2015-052126.250

Background/introduction Guidelines highlight the need to increase HIV testing amongst men-who-have-sex-with-men (MSM) as a priority and recommend MSM at high risk of HIV test for every three months. Novel point of care testing (POCT) provides new possibilities for delivery of care. However, it is unclear how POCT should be used to best effect.

Aim(s)/objectives This study aimed to increase understanding of sexual risk-taking behaviour, service use and attitudes to POCT amongst sauna clients.

Methods Data were collected within two saunas for MSM in south west England using a self-completion survey on a computer tablet device.

Results 134 men participated (74% response rate). Half of participants (51%) reported unprotected anal intercourse (UAI) with a casual partner in the previous three months. For those reporting UAI, 19% reported having an STI test and 16% had taken an HIV test in the previous three months. Participants reported they would be more likely to be tested for HIV (84%), gonorrhoea (91%), chlamydia (90%) and syphilis (90%) if available as rapid POCT to avoid a stressful wait. The majority of men (52%) would prefer to receive POCT at NHS sexual health clinics.

Discussion/conclusion Though this sample of sauna clients are at high risk of acquiring an STI, the testing frequency amongst the majority of those reporting UAI is not in keeping with national guidelines. For almost all participants the introduction of rapid POCT for both genital and blood-borne infection was likely to increase testing and for the majority NHS specialist services was the preferred setting.

P207 SYPHILIS: SIGNIFICANT INCREASE IN MEN WHO HAVE SEX WITH MEN (MSM) SINCE NOVEMBER 2013

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10.1136/sextrans-2015-052126.251

Background High rates of infectious syphilis have been reported in MSM. Locally 1:10 of the population are estimated MSM and high rates of HIV and sexually transmitted infections are seen.
Methods We identified cases of infectious syphilis in MSM per month from February-2013 to June-2014 attending sexual health services. Age, ethnicity, HIV status and syphilis re-infection were noted. The total number of MSM seen in sexual health was used as a denominator for incidence calculations and rates were compared using Chi-square and Mann-Whitney test.
Results 207 new cases of infectious syphilis were identified over the study period. The median age was 36 years (19–60), 96/207 (46.4%) were HIV+ and 3/207(1.4%) had syphilis re-infection. The median incidence of syphilis from February to October 2013 was 8.6/1000 MSM; this increased significantly to 25.9/1000 MSM from November–June 2014 [chi-square 67.447 ($p < 0.0001$). There was no significant difference in the percentage co-infected with HIV between these time points (February-October = 57%, November-June = 46% [Mann-Whitney = 16.5, $p = 0.0581$).
Conclusion We describe a significant increase in the incidence of infectious syphilis in MSM from November 2013. This rise is likely attributable to changes in sexual behaviour among MSM: increased accessibility to sex driven by social media, increased anonymous and group sex and growing use of party drugs. Locally we are working with the Terrence Higgins Trust and public health teams to increase awareness among MSM and primary care.

P208 MEN'S BEHAVIOUR CHANGE FOLLOWING A POSITIVE AND NEGATIVE DIAGNOSIS FOR CHLAMYDIA

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10.1136/sextrans-2015-052126.252

Background/introduction Young men aged 20 to 24 years who are screened through the National Chlamydia Screening Programme have a high rate of infection. The majority of them choose to self-request screening via anonymous postal testing as opposed to seeking alternative health service provision.
Aim(s)/objectives To explore the complex factors involved in men's sexual health decision making following a request for an internet test for chlamydia.
Methods Ten young men who had requested a test for chlamydia via the internet were recruited through the North of Tyne Chlamydia Screening Programme. Data were collected through in-depth interviews, follow-up interviews at 12 months and patients' NHS health records.
Results Decisions about sexual partners and sexual practice were based on men's perceptions and belief about women, categorising them as 'risky' with a sexually transmitted infection or 'clean' with no infection. Factors influencing decisions to seek testing were triggered by unprotected sex with casual partners, strengthened by catalytic influences including media campaigns. The findings suggest a negative chlamydia test result gave respondents a clean bill of health allowing them to engage in further unprotected sex. A positive diagnosis resulted in short-term behaviour change and modified sexual practice. After follow up interviews, behaviour change was not maintained and many became re-infected within 6 months.
Discussion/conclusion This has implications for the transmission of chlamydia infection in terms of infection spreading, re-infection of partners and complications to their own health. Further work is required around interventions for chlamydia screening which focus on behaviour change as opposed to screening volume.

P209 'THE GRAND SLAM': SURVEYING THE LOCAL LANDSCAPE OF 'CHEMSEX' DRUG USE AMONGST MSMs IN A COMMUNITY OUTREACH SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.253

Background 'Chemsex' is the use of recreational drugs before and/or during sex by men who have sex with men (MSM). Concern exists among health professionals about this practice particularly in relation to transmission of HIV and sexually transmitted infections (STIs). There is little data about use of Chemsex outside London.
Aims/objectives To generate a profile of Chemsex use amongst MSM accessing a community outreach sexual health clinic.
Methods In 2014 a local code was introduced to identify reported use of Chemsex. A retrospective case note audit was undertaken of patients identified during 2014.
Results 636 patients attended for STI screening in 2014. Overall 24% had an STI. There were 46 attendances in 40 MSM where Chemsex was reported. The average age was 35(19–62). 24/40 (60%) were single. 39/40(98%) reported oral sex, 30/40(75%) insertive and 27/40(68%) receptive anal sex with only 6(15%) reporting consistent condom use. Mephedrone (MCAT) was the most commonly used drug, reported by 33/40(83%). Gammabutyrolactone (G) was used by 10/40(25%). Crystal Meth (Meth) was used by 7/40(18%). 9/40(23%) used MCAT combined with G. 2/40(5%) used all three drugs. 35/40(88%) were asymptomatic. 23/40(58%) had previously had an STI. 6/40(15%) were HIV positive.16/40(40%) patients were diagnosed with an STI (13 gonorrhoea (3 dual site site) and 6 chlamydia (all single site) and 3 both chlamydia and gonorrhoea.
Discussion/conclusions Introduction of a local code has given insight into Chemsex use amongst MSM. We have updated the clinic history proforma to identify high risk behaviour, allowing targeted intervention to facilitate positive behavioural change.

P210 UPTAKE AND ACCEPTANCE OF COMBINED HIV POCT AND STI SCREENING FOR MSM IN COMMUNITY SETTINGS DURING NATIONAL HIV TESTING WEEK

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10.1136/sextrans-2015-052126.254

Background/introduction National HIV Testing Week (NHTW) aims to increase the earlier detection and treatment of HIV by increasing access to testing across community and statutory settings, with a focus on at risk populations including men who have sex with men (MSM). However there are increasing concerns about risky behaviour, including Chemsex, and an increase in other STIs in MSM.
Aims/objectives To review the acceptance by MSM, of full sexually transmitted infection (STI) screening in a community setting, during NHTW.
Methods We promoted NHTW using national and local material, shared across social media platforms aimed at MSM. In addition to HIV point of care testing (POCT) using a 4th generation test, we offered full STI screening (urine and self-taken pharyngeal/rectal swabs for chlamydia and gonorrhoea NAATs and syphilis POCT). Sexual histories were self-completed.
Results 74 patients were screened; 56 identified as MSM; average age 33(17–75). Of these only 21(38%) reported consistent condom use for anal sex. 4(7%) reported Chemsex, with MCAT the commonest drug. 20(36%) had a past history of an STI. 42(75%) underwent full screening, 12(21%) POCT only (10 HIV and syphilis, 2 HIV), and 2(4%) for chlamydia and gonorrhoea only. There were 3 positive diagnoses: 1 HIV, 1 pharyngeal gonorrhoea and 1 rectal chlamydia.
Discussion/conclusion NHTW has proven its effectiveness in increasing the uptake of HIV testing in at risk populations; we have shown that offering full sexual health screening as part of NHTW activity, using self-taken history and urine / non-invasive swabs, is acceptable and effective.

P211 MSM THE COST OF HAVING A GOOD TIME? A SURVEY ABOUT SEX, DRUGS AND LOSING CONTROL

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10.1136/sextrans-2015-052126.255

Background Men who have sex with men (MSM) suffer substantial health inequalities compared to the rest of the population relating to sexual health, mental health and drug use. Increasing substance misuse in a sexualised context (chemsex) has been linked to risky sexual behaviour and STI acquisition.
Aims Determine the prevalence of chemsex in our local MSM population, and associated risks to sexual health.
Methods Men attending a GU clinic during December 2014, who identified as MSM, were invited to complete an anonymous questionnaire. 53 questionnaires were received.
Results Overall, 53% reported some form of recreational drug use. 38% reported having chemsex. Chemsex participants were more likely to use mephodrone and Viagra than ecstasy and cocaine used more frequently by other party drug users. 47% of MSM surveyed used the internet to meet partners. The number of partners (any kind of sexual contact) was similar for MSM using drugs and those not. Unprotected receptive anal sex, including with a partner of unknown HIV status, was higher for MSM reporting chemsex. Men reporting chemsex were less likely to have an up-to-date HIV test (40% untested in previous year). Overall 40% reported having an STI in the last year (most commonly Gonorrhoea). All those receiving an HIV diagnosis in the last year (n = 3) were amongst the chemsex group. 49% reported a mental health problem, with 60% of chemsex participants having a history of depression and/or anxiety.
Conclusion Tackling the sexual health inequalities of MSM is complex, with substance misuse, social media, and mental wellbeing having an increasing influence.

P212 DO YOU KNOW WHO THE MALE SEX WORKERS ARE IN YOUR COHORT?

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10.1136/sextrans-2015-052126.256

Background/introduction Pro(TECT) is a bespoke service for male sex workers (MSW) launched by THT in June 2014. The service provides MSW with point of care HIV tests, STI and blood borne virus screening, as well as motivational interviewing, harm reduction and signposting to local SH services.
Aim(s)/objectives To describe the sexual health of MSW engaging with the local GU clinic.
Methods The notes of the Pro(TECT) clients who attended the local GU clinic were reviewed.
Results 15 MSW aged 20–57 years, attended the Pro(TECT) service from June to December 2014. 87% (13/15) had ever attended the GU clinic; 10 in the last 12-months. Only 3 revealed they were MSW. 39% (5/13) were HIV positive, of whom 3 had detectable viral loads (42,000 to 307, 000 copies/ml). CD4 counts ranged from 6–698 $\times$ 10^6/l. 85% were hepatitis B immune; 1 was hepatitis C co-infected (viral load 100, 4492 cp/ml).

33 STI screens were performed in the last 12-months, with an average of 3 screens/person. 39% (5/13) had an acute STI: 4 rectal, 3 pharyngeal, 1 urethral gonorrhoea; 2 rectal chlamydia; 1 latent (early/late) syphilis. PEP was used by 2 of the 5 HIV negative MSW a total of 5 times in 12-months.
Discussion/conclusion There is a high burden of STIs in this group and a significant risk of onward transmission. MSW may not disclose their work to health care professionals (HCP), even on direct questioning. Identification of MSW is fundamental in order to reduce risk and minimise harm. Pro(TECT) acts as a unique gateway into mainstream services, including advice to access PEP.

P213 PRO(TECT) SERVICE – ENGAGING WITH MALE SEX WORKERS

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10.1136/sextrans-2015-052126.257

Background/introduction Pro(TECT), a bespoke service for male sex workers (MSW), was launched in June 2014 by THT to engage with local high-risk MSM. Motivational interviewing (MI) is used to explore behaviour change; clients are offered a wide range of support to improve sexual health and reduce onward STI/HIV transmission. Analysis of behaviour and service evaluation was performed at 6 months.
Methods All clients (15) completed an online survey regarding sexual practices, drug/alcohol use and experience of the service.
Results In the last 12 months: 70% reported insertive UAI; 40% receptive UAI; 36% diagnosed with an STI; 29% HIV positive; 21% injected drugs; 43% under the influence of drugs/alcohol while selling sex; 33% self-harmed in last 12 months.

Abstract P213 Table 1 Feedback on MI sessions (33 interventions)

	Strongly Agree/Agree	Not Agree
"My knowledge on SH has improved"	80%	20%
"My confidence to look after my SH has improved"	80%	20%
"My motivation to look after my SH has improved"	93%	7%
"My knowledge on the different ways I can test for HIV/STIs has improved"	69%	31%
"My knowledge of PEP/where to access has improved"	54%	46%
"My confidence in managing or abstaining from drugs/alcohol; making better choices with regard to my SH has improved"	93%	7%

Conclusions Unprotected sex is common among MSW. Early MI results show good improvement in knowledge and risk taking behaviour. High levels of drug/alcohol use and self-harm require close links to mental health services. Pro(TECT) is unique in accessing this 'hard-to-reach' population and offers a holistic service of harm reduction.

P214 ARE WE MISSING SOMETHING? EXTRA-GENITAL CT/GC NAAT TESTING IN FEMALE PATIENTS ATTENDING A YOUNG PERSONS CLINIC

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10.1136/sextrans-2015-052126.258

Background/introduction Our service has a dedicated Young Persons Clinic (YPC) for women age 25. Current policy is to only offer routine vulvo-vaginal (VVS) or cervical CT/GC NAAT swabs for female patients but we are aware that STIs in non-genital sites may therefore be missed. From 15/04/14 we offered female patients attending our YPC VVS/cervical and extragenital (throat and rectum) swabs, regardless of exposure stated.

Aim(s)/objectives To quantify the number and result of CT/GC extragenital samples from YPC female patients.

Methods NAAT results for all women attending YPC between 15/04/14–16/09/14 were extracted retrospectively from an electronic database held within the clinic.

Results

	Number of patients	%
STI Screens	193	
Acute STI diagnosed at that visit (including TV and PID)	29/193	15
Positive CT/GC NAAT at that visit	24/193	12
More than one site sampled	34/193	18
with positive extragenital CT/GC NAAT *and negative VVS/cervical CT/GC NAAT	4/34	12

*GC throat × 2, CT throat × 1, CT throat + GC rectal × 1

42 patients were documented to have been offered extragenital swabs. Of those, 34 (81%) accepted.

Discussion/conclusion Uptake of extragenital site testing was low. This is likely to reflect low rates of offering extragenital swabs, as there was a high rate (81%) of acceptance where an offer was documented. Five infections were solely identified from extragenital testing. It is recognised that a positive result does not necessarily imply infection and extragenital tests are currently unlicensed. Therefore this data suggests that further review would be useful.

P215 DELIVERING STI SERVICES IN HOSTELS FOR HOMELESS INDIVIDUALS

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10.1136/sextrans-2015-052126.259

Background/introduction Residents of hostels for homeless individuals have a disproportionate burden of mental and physical health needs, which can expose them to risk of blood born viruses (BBVs) and STIs. Our borough runs 5 hostels which address health and social needs as well as provide accommodation.

Aim(s)/objectives To report on a pilot aiming to improve diagnosis and treatment of BBVs and STIs of residents of these 5 hostels.

Methods Between 14/02/2012 and 14/02/2013 five hostels were visited a minimum of two times. CT/GC NAATs and HIV, Syphilis, Hepatitis B and C serology were offered as well as signposting to other services.

Results

Number of residents:	
- Seen	56
- With past/current IVDU	36/56 (64%)
- With known HIV	3/56 (5%)
- With known HCV	6/56 (10%)
- Who had previously tested for HIV	41/56 (73%)
- Who had tested for HIV in the preceding year	29/56 (52%)
- Who had BBV serology on visit	21/56 (38%)
- Who had BBV serology on visit that had not previously tested	8/56 (14%)
- Who had CT/GC testing on visit	54/56 (96%)
New positive diagnoses	1/56 (2%) – HCV

Discussion/conclusion Half the residents had been tested for HIV in the preceding year. 14% had never previously tested for BBV. 38% accepted BBV testing at this service and 96% accepted CT/GC testing. One new infection was diagnosed. This suggests that existing services meet the needs of the majority of this group. However, this additional service provided support to a minority of individuals who had been unable to negotiate existing services.

P216 MONITORING GENDER RATIO OF GASTROINTESTINAL INFECTION LABORATORY REPORTS AS A MECHANISM FOR IDENTIFYING POSSIBLE INCREASES AMONG MEN WHO HAVE SEX WITH MEN, ENGLAND, 2003–2013

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10.1136/sextrans-2015-052126.260

Background Since 2011, an increase in Shigella flexneri has been observed in men due to faecal-oral transmission associated with sexual contact between men who have sex with men (MSM). Sexual history is not routinely collected for cases of gastrointestinal infections.

Aims To use gender ratio to detect greater than expected numbers of gastrointestinal infections in MSM.
Methods We examined annual male to female ratios of laboratory confirmed patient-episodes from those aged 16–65 years with no known history of travel for eight gastrointestinal pathogens (Campylobacter, Cryptosporidium, Giardia, Hepatitis A, Norovirus, Salmonella, Shigella, and VTEC) in England between 2003 and 2013. Chi-squared tests for linear trend were conducted and a male to female ratio of more than two was considered suggestive of an excess. Sub-analyses by age and high-risk areas (London, Brighton and Manchester) were conducted.
Results An increased linear trend and excess of male episodes was observed for Shigella ($p < 0.001$; m:f ratio of 2.0 and 2.5 in 2012 and 2013, respectively) but not the other gastrointestinal infections. Consistent with MSM-mediated transmission, the excess of male Shigella episodes was most pronounced among those aged 25–49 years (ratios of 2.4 and 2.9) and those in high-risk areas (ratios of 2.9 and 4.0); no excess was observed among children.
Conclusion This method identified the recent outbreak of Shigella and routine application might alert public health authorities to some future gastrointestinal infection outbreaks in MSM. Utility of this approach to detect excess episodes among MSM is likely to be pathogen specific and dependent on several factors including R0.

P217 HIGH DEMAND FOR AN MSM CLINIC PILOT IN A DISTRICT GENERAL HOSPITAL

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10.1136/sextrans-2015-052126.261

Background/introduction A tailored sexual health service for men who have sex with men (MSM) was piloted in a district general hospital. This was in response to a 'Gay Pride' survey in which 80% of surveyed attendees requested a specialised local service.
Aim(s)/objectives This clinic explored the feasibility and acceptability of a targeted MSM service in the district general hospital setting.
Methods The pilot had 9 clinics over 3 months. Each patient was fast-tracked to a multidisciplinary team (doctor, nurse and health advisor). A rapid HIV test (result within 24 h) was offered to every patient as point of care testing was unavailable in the service. Data and patient feedback were analysed in SPSS version 22.
Results A total of 13 patients attended the clinic (new, N = 12, follow up, N = 1). Age range was 22 to 67 years old (mean 33.7, standard deviation 13.27) and all were Caucasian. 6/13 attended for an asymptomatic screen; the prevalence of sexually transmitted infections (STI's) was 46%. All tested HIV negative. 61.5% had no prior immunity to Hepatitis B. 92.3% considered the rapid HIV test an incentive to attend and 100% wanted a future point of care test. There was favourable patient feedback.
Discussion/conclusion The clinic pilot was positively received and the majority rated it preferable to the routine genitourinary clinic. There was a high prevalence of STI's and high rate of opportunistic Hepatitis B vaccination. There is a notable demand for rapid HIV testing. Our tailored MSM clinic encouraged attendance in a high risk provincial population.

P218 RISING STI RATE IN FEMALE SEX WORKERS ATTENDING AN INNER CITY DEDICATED CLINIC

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10.1136/sextrans-2015-052126.262

Background/introduction Our GUM service has a dedicated sex worker (SW) clinic. In 2014 there was an anecdotal increase in in CT and GC diagnoses in patients attending this clinic therefore a retrospective case note review was performed to assess this observation and explore causal factors.
Aim(s)/objectives To compare number of CT/GC infections in the SW clinic in 2012 and 2014.
Methods Notes were reviewed for age, ethnicity and CT/GC codes in all patients seen in 2012 and 2014. The notes of those found to be CT or GC positive had a more detailed review for type of services offered, condom use, place of work (i.e. flat, sauna). Chi-squared test was used to calculate p value.
Results

Abstract P218 Table 1 STI rates in female sex workers

Year	2012	2014	P value
Number of patients:			
- Attending	192	140	
- Age Range	19–58	19–54	
- With either CT or GC at least once	5/192 (2.6%)	19/140 (13.6%)	0.0002
- With both CT and GC concurrently	0	3/140 (2.1%)	
- That had repeat infections in the same year	0	3/140 (2.1%)	
Total number of CT infections	4	16	
Total number of GC infections	1	11	

Discussion/conclusion There was a significant increase in STIs from 2012 to 2014. In addition, concurrent CT and GC infection and repeat infections were seen in 2014, but not in 2012. This observation has guided an update in patient education materials and a more targeted approach to outreach. Possible infection clusters are being explored.

P219 DOES A SPECIALISED MSM CLINIC IN A DISTRICT GENERAL HOSPITAL ATTRACT A RISKIER POPULATION?

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10.1136/sextrans-2015-052126.263

Background/introduction A sexual health service for men who have sex with men (MSM) was piloted due to local demand for a specialised clinic with an understanding of MSM risk taking behaviour and sexual practices.
Aim(s)/objectives To explore if an MSM clinic in a district general hospital attracts a patient population with riskier sexual behaviour compared to the normal genitourinary (GU) service.
Methods Risk data was collected from all MSM patients attending the specialised and routine GU clinics over a 3 month period using self-completed questionnaires. 'High risk' behaviour was classified as any of the following within the past 3 months: group sex, sex parties, chem-sex, casual partner sourcing online, sexual activity in London and number of partners. Data were analysed in SPSS version 22.
Results Total sample size was 40 (MSM clinic, N = 13, GU clinic, N = 27). Age range was 18 to 67 years old (mean 32.47,

Abstract P219 Table 1 Risk data for patients attending the MSM clinic and routine GU clinic

Patient group	Number of partners in the past 3 months	12 or more partners in the past 3 months	Group sex	Sex parties	Chem-sex	Casual partner sourcing online	Sexual activity in London
MSM clinic (n = 13)	Mean = 6.4 Mode = 4	15.4%	38.5%	23.1%	30.8%	100%	53.8%
GU clinic (n = 27)	Mean = 4.5 Mode = 2	7.4%	37%	11.1%	14.8%	70.4%	22.2%
p value		p = 0.392	p = 0.599	p = 0.293	p = 0.211	p = 0.029	p = 0.021
Reason for attending MSM clinic	Less stigma	STI screen	Tailored service	Advice and support	Rapid HIV test		
Total number of responses	3	4	5	6	6		

standard deviation 11.48). Patients from both groups were involved in all behaviours, however MSM clinic patients were more likely to engage in risky sexual activity in London (p = 0.021) and source casual partners online (p = 0.029) compared to the GU clinic population.

Discussion/conclusion The MSM clinic attracted a population with riskier sexual behaviours. Patients cited non-judgemental acceptance and understanding of MSM sexual practices as pivotal for attending. Perceived reduction in stigma, rapid HIV testing and tailored advice has encouraged service engagement; this provides a valuable opportunity to screen and vaccinate patients at high risk of sexually transmitted infections.

P220 EXPANDING SEXUAL HEALTH OUTREACH PROVISION FOR SEX WORKERS IN THE COMMUNITY

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10.1136/sextrans-2015-052126.264

Background/introduction Isolation of six consecutive cases of gonorrhoea amongst sex workers (SW) in 2012 led to a multi-agency review of sexual health provision for this hard to reach group. It identified reluctance to access traditional integrated sexual health services in the area, so a more extensive community based outreach approach was implemented.

Aim(s)/objectives To observe the uptake of sexual health screening and contraception in the community amongst SW.

Methods Case note review of all SW seen in the community by the sexual health outreach nurse from July 2013 to January 2015.

Results 99 SWs were seen during the study period. Median age 26(range 17 to 50), 95 were female with the majority identifying as white UK (65). 73 worked exclusively in sex parlours. 12 STIs were diagnosed amongst 98 SW screened. Of the 22 current IVDUs 11 tested positive to Hepatitis C whilst 3 were already known to have the infection. 96 SWs had used one or more forms of contraception prior to consultation including 92 who used condoms. Of female SW 22 commenced or continued injectable contraception and cervical cytology was performed on 18. Uptake of Hep B vaccination was consistent (73) with 24 already vaccinated or known to be Hep B immune.

Discussion/conclusion Partnership working enhanced referral pathways, making access to sexual health screening easier for this hard to reach group. An increased uptake of STI screening, contraception and detecting untreated infections demonstrates that a flexible and opportunistic approach is beneficial for this client group.

P221 DRUG AND ALCOHOL MISUSE IS ASSOCIATED WITH STIs IN MEN WHO HAVE SEX WITH MEN (MSM)

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Background/introduction Alcohol and recreational drug misuse is an increasing problem in sexual health clinics, particularly MSM where it is often associated with unsafe sexual practices and increasing prevalence of sexually transmitted infections (STIs).

Aims/objectives To determine the proportion of MSM testing positive for STIs reporting substance misuse in a dedicated sexual health clinic, compared to the proportion attending THT services reporting high risk sexual activity requiring support for substance misuse.

Methods Case notes of patients attending a MSM clinic testing positive for STIs over a 6 month period were reviewed. Data was collected on type of STI, recreational drug and alcohol use. Over the same period, data on high-risk sexual activity and referral to specialist drug and alcohol services was collected for MSM attending THT services.

Results 285 MSM attended the sexual health clinic, whereby 97 (34%) tested positive for 1 or more STI. 88 cases of gonorrhoea were seen, 49 cases of chlamydia, 20 cases of syphilis and 7 new HIV infections. Of those testing positive for STIs, 45 (46%) reported alcohol and/or recreational drug misuse. Of the 162 MSM attending THT services, 90 (56%) reported high risk sexual behaviour with concurrent substance misuse. 27 (30%) were referred to specialist substance misuse services.

Discussion/conclusions High rates of substance misuse associated with high risk sexual activity were seen in the MSM clinic and at THT. This reinforces the importance of screening and brief intervention/referral for substance misuse as a risk reduction strategy for STIs and HIV.

P222 MULTIDISCIPLINARY AND MULTIAGENCY WORKING IN A METROPOLITAN YOUNG PEOPLE'S SEXUAL HEALTH CLINIC

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10.1136/sextrans-2015-052126.266

Background/introduction A weekly multidisciplinary team meeting (MDTM) was introduced to discuss clinically or

psychosocially complex cases, facilitate multiagency (MA) working and ensure safeguarding of vulnerable young people accessing services.
Aim(s)/objectives To describe characteristics of young people accessing the service and compare those warranting MDTM or MA input to those in whom this was not required.
Methods Retrospective review of electronic patient records of new patients accessing a young people's clinic (18 years) from January to June 2014. Demographics, clinical and psychosocial details, MDTM case note entries or liaison with other agencies including social services, voluntary sector, mental and other health were analysed. Significance calculation: fisher's exact test.
Results 159 cases reviewed. Median age 16 years: female 80%, locally resident 80%, self-referral 77%, white British 22%, black Caribbean 22%. 67(42%) required MA/MDTM working. (45%, n = 30 had MA referral/liaison). MA/MDTM patients were more likely to have health adviser input: 57% vs 21% p = 0.0001, report mental health problems: 33% vs 3% p = 0.0001, have a social worker: 27% vs 7% p = 0.0003 or if female, not on contraception: 60% vs 39% p = 0.005. Amongst those requiring MA/MDTM input 12% (n = 8) had a safeguarding concern and 7% (n = 5) were identified as at risk of sexual exploitation.
Discussion/conclusion MDTMs effectively enabled discussion of complex patients. MDTM/MA working was common and such cases were more likely to: lack contraception, need health adviser input, have a social worker and mental health problems highlighting an opportunity for closer working with mental health services.

P223 UNDERSTANDING THE GREATER BURDEN OF STIs AMONG BLACK CARIBBEANS IN THE UK: EVIDENCE FROM A SYSTEMATIC REVIEW

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10.1136/sextrans-2015-052126.267

Background In the UK, Black Caribbeans are disproportionately affected by STIs.
Aim We conducted a systematic review of attitudinal, behavioural and contextual risk factors of this inequality.
Methods Ten electronic databases were searched for studies on risk factors and drivers of STI among UK Black Caribbeans from 1948 to 30/11/2014. Two independent reviewers screened all identified abstracts and extracted data from selected studies using standardised forms.
Results Of 3220 abstracts identified, 165 were included in the review. STI risk among Black Caribbeans is higher compared to other ethnic groups and varies by gender and age. Being single and reporting first intercourse aged <16, >1 new sex partner in the past year, concurrency, and assortative sexual mixing were identified as risk factors. STIs were considered of lower priority than HIV/unplanned pregnancy. Barriers to condom use, especially among women with older and regular partners, were reported. Compared to other ethnic groups, Black Caribbeans were more likely to have ever attended a STI clinic and tested for HIV, but Black Caribbean women were more likely to report delays in seeking care and be sexually active whilst symptomatic. Perceived negative attitudes of clinic staff of the same ethnicity towards young women negatively affected care-seeking.
Discussion/conclusion Sexual behavioural risk factors or access to care did not fully explain the disproportionate STIs burden among Black Caribbeans highlighting the need for further evidence on contextual drivers of STIs. STI reduction interventions should be gender-specific, informed by partnership patterns and address attitudes to STIs and sexual health care-seeking.

P224 THE SEXUAL HEALTH OF THE HOMELESS – AN OUTREACH SEXUAL HEALTH SCREENING PROJECT

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10.1136/sextrans-2015-052126.268

Background/introduction Homeless people are at increased risk of STIs, and may struggle to attend conventional services. To improve sexual health access and knowledge for this group, THT launched a weekly outreach testing project for asymptomatic clients in June 2014 at the local homeless service. HIV point of care tests (POCT) and self-taken STI screens (SHS) were offered. Hepatitis B/C POCTs were introduced more recently.
Aim(s)/objectives To assess the value of the outreach service and describe project outcomes.
Methods User demographics and testing outcomes were collected at each attendance and reviewed at 6 months.
Results From June to December 2014, 129 clients presented. 83% were white British, 92% were male. The mean age was 36 (range 19–65 years). 84% identified as heterosexual, 14% bisexual and 2% homosexual. Only 26% had previously tested for HIV. Of the asymptomatic service users, 45% had a HIV test (all negative) and 23% had a self-taken SHS. Two cases were positive; one urethral chlamydia, one rectal gonorrhoea. Eighteen referrals were made to the local SH clinic for symptomatic screens, blood-borne virus (BBV) testing, vaccination and contraception. Since introducing hepatitis POCTs 2 weeks ago, 4 clients have tested and 2 were positive for hepatitis C.
Discussion/conclusion Prior to project launch, this client group had significant anxiety regarding HIV and BBV. Having the ability to access a full SH screen in familiar surroundings was welcomed. A significant number of infections have been identified demonstrating the importance of the outreach project, and the need for strong links with mainstream services.

P225 REACH OUT AND TEST ME

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10.1136/sextrans-2015-052126.269

Background Saunas have traditionally been where MSM participate in risky sexual activities, contracting high numbers of sexually transmitted infections (STIs) and have been ideal targets for sexual health outreach work. There has however been a recent trend towards private "Chem-Sex "parties arranged through social media. Is sexual health outreach work in the saunas still justified, particularly in these financially pressured times?
Aim Comparison of outreach services in a large urban centre in 2011 and 2013.
Methods Retrospective case-note review of patients who accessed outreach services July–December 2011 and 2013.

Results In 2011, 98 case notes were reviewed. The rate of infection was 28.2%.

In 2013, 89 case notes were reviewed. The overall rate of infection fell to 14.6%. However, 46% had never attended our GUM clinic and among these the infection rate was 22%. The comparative rate in MSM attending clinic was 8.7%. Of those new to our services 19% had never attended any GU service and of these 82% had never tested for HIV.

Conclusion Our outreach team tested a significant number of patients with a high burden of infection who had never accessed services. However, the team is taken from conventional clinics; due to staff shortages in the clinic, patients are turned away. A balance needs to be found between financial constraints and reducing infection in hard-to-reach populations. Collaboration with voluntary organisations and saunas will be the key to our success. We are currently setting up a Chem-Sex clinic to target evolving at risk populations.

P226 A YEAR OF 'SEX, STEAM AND STIS'

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10.1136/sextrans-2015-052126.270

Background/introduction This sauna clinic was set up as recent HIV infection amongst MSM in our city is higher than the national average. Following a successful 6 month pilot, the clinic was commissioned for another year.

Aim(s)/objectives

- Provide accessible, convenient sexual healthcare/promotion for 'hard-to-reach' individuals.
- Promote regular STI testing amongst this high-risk group.
- Assess measurable outcomes to determine the service's success.

Methods A weekly nurse-led clinic was set up at the sauna. Rectal, pharyngeal and urine testing for chlamydia and gonorrhoea were offered, with HIV, hepatitis B/C and syphilis testing and Hepatitis B vaccination. Identified infections were treated at the sauna clinic or our GUM clinic.

Results 231 new/rebook episodes over 57 clinics. 80% had previously accessed sexual health services but only 63% had previously undergone extra-genital sampling. HIV testing uptake was 96%. 16% had never tested for HIV; 22% last tested over a year ago. 20% reported sex with men and women. 18% had at least one of chlamydia, gonorrhoea, HIV or syphilis identified, compared with 14% amongst asymptomatic MSM attending our GUM clinic. 80% of chlamydia and gonorrhoea infections identified were purely extra-genital. 6 new HIV diagnoses were made, 4 of which were recently acquired HIV. HIV prevalence was 3%.

Discussion/conclusion The service has been continually modified to optimise attendance. A new initiative introduced by the sauna management team includes discounted sauna entry for clients attending the sauna clinic. This clinic's success has been due to close partnership and collaboration between NHS, third sector, private sector and local commissioners.

P227 SEXUAL HEALTH IN TRANS* INDIVIDUALS: HIGH RISK AND UNDER REPRESENTED

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10.1136/sextrans-2015-052126.271

Background/introduction In the UK, the prevalence of sexually transmitted infections (STI) amongst trans* individuals is unknown. International data estimate HIV prevalence to be as high as 20%. Public health data is lacking primarily due to trans* not being recognised as a gender.

Aim(s)/objectives To identify and characterise trans* individuals within our HIV+ cohort.

Methods Trans* individuals attending for HIV care at three urban care centres were identified by their physician and added to a database. A retrospective review of each electronic patient record was undertaken. Demographics, clinical data and documentation of sexual history and risk behaviours were collated.

Results 23 trans* individuals living with HIV were identified. All were trans*female. 10 (43%) had a detectable HIV viral load. Within the past 6 months 10 (43%) reported condomless anal sex and 6 (26%) had gonorrhoea and/or chlamydia infection. 11 (48%) were regularly using recreational drugs and 6 (26%) engaged in commercial sex work. 9 (39%) had no documentation of sexual history.

Discussion/conclusion High levels of vulnerability and specific healthcare needs exist amongst trans* individuals. Within this HIV+ cohort particular concerns include risk of onward transmission of HIV, acquisition of new infections and drug misuse. Our clinic runs a dedicated sexual health, HIV and holistic wellbeing service for trans* individuals that is working to address these issues. Patient record systems need updating to recognise trans* individuals, allowing the prevalence of HIV and other STIs in this group to be accurately recorded. We believe trans* individuals are an at risk group whose healthcare needs should be better addressed.

P228 SEXUALLY TRANSMITTED INFECTIONS – A PREDICTIVE FACTOR FOR CHILD SEXUAL EXPLOITATION?

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10.1136/sextrans-2015-052126.272

Background/introduction Sexually active young people can be at risk of child sexual exploitation (CSE). It has been assumed that the presence of a sexually transmitted infection (STI) should be used a marker of increased risk, however no clear evidence exists to support this.

Aim(s)/objectives We aimed to identify if a relationship exists between the detection of STI and other indicators for CSE, by comparing to a matched control group who tested negative for STI.

Methods Utilising our service's electronic patient record, which automatically prompts staff to risk assess, we identified that 1228 patients aged 15 yo were seen between 01/04/2013 and 31/03/2014, 52 of whom tested positive for STI. Their notes, plus a control group of 105 patients were reviewed for potential identifiers of CSE.

Results We identified no statistically significant association between testing positive for STI and other predictive factors for CSE.

Discussion/conclusion In this small study we found no significant increase in commonly used indicators for CSE in those who tested positive for STI. This highlights the importance of using several identifiers when assessing for CSE and the need for incorporating alternative screening tools such as Spotting The Signs.

Abstract P228 Table 1

Variable	STI positive	Control	p-value
Non-consensual intercourse	9.62%	11.43%	0.7606
Other agencies involved	46.15%	40.00%	0.4622
School issues	15.38%	14.29%	0.8546
DSH/ED	3.85%	10.47%	0.2611
Alcohol misuse	23.08%	16.19%	0.3073
Drug misuse	17.31%	13.33%	0.6069

P229 ARE CASES OF GONORRHOEA RISING IN VERY YOUNG PATIENTS IN SOUTH WEST LONDON? A RETROSPECTIVE CASE REVIEW OF PATIENTS AGED 18 YEARS AND YOUNGER DIAGNOSED WITH GONORRHOEA IN A LONDON TEACHING HOSPITAL GUM SERVICE

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10.1136/sextrans-2015-052126.273

Background Cases of Gonorrhoea continue to rise in the UK and young people (YP) remain disproportionally affected despite efforts to reduce infection rates.
Aim To identify if there been a true rise in Gonorrhoea cases in very YP (18 years) attending our GUM service.
Methods We identified all GUM (New and Rebook) attendances and Gonorrhoea diagnoses from 01/01/2011–31/12/2014 in patients 18 from MILLCARE. Electronic records were reviewed for demographics, infection site (s), antimicrobial resistance, re-infection and Chlamydia co-infection.
Results

	Number of GUM attendances (% of total annual GUM attendances)			Number of Gonorrhoea diagnoses (% of annual GUM attendances by gender and total)		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
2011	111 (22.0%)	393 (78.0%)	504	0 (0%)	5 (1.3%)	**5 (1.0%)**
2012	135 (21.0%)	508 (79.0%)	643	1 (0.7%)	16 (3.1%)	**17 (2.6%)**
2013	482 (21.5%)	1764 (78.5%)	2246	7 (1.5%)	33 (1.9%)	**40 (1.8%)**
2014	237 (19.5%)	980 (80.5%)	1217	7 (3.0%)	30 (3.1%)	**37 (3.0%)**
Total	965 (20.9%)	3645 (79.1%)	4610	15 (1.6%)	84 (2.3%)	**99 (2.1%)**

There were 99 Gonorrhoea diagnoses in 84 patients, 94/99 (84.4%) in females and 15/99 (15.2%) in males (5/15 (33.3%) MSM). 1/84 (1.2%) was HIV+ (MSM). 26/99 (26.2%) infections were in White, 19/99 (19.2%) in Caribbean/Mixed-Caribbean, 11/99 (11.1%) in African/Mixed-African and 7/99 (7.1%) in Other-Mixed ethnicities. 80/84 (95.2%) were UK born. Age range was 15–18.

83/99 (83.8%) were genital and 12/99 (12.1%) were multiple site infections. We found concurrent Chlamydia in 53/99 (53.3%). Antimicrobial resistance was detected in 15/68 (22%) culture+ cases, 13/15 (86.7%) in females and 2/15 (13.3%) in MSM. 11/84 (13.1%) patients had 1 re-infection (positive test at 3 months), 10/11 (90.9%) females and 1/11 (9.1%) MSM. Mean time to re-infection was 5.1 months.
Discussion NAAT testing was introduced into our service preceding the study period. We found Gonorrhoea diagnoses in patients 18 have increased three-fold in 4 years in our clinic with high rates of Chlamydia co-infection, antimicrobial resistance and re-infection. MSM, females and patients of Black/Mixed ethnicity are disproportionally affected. Further work is required to investigate factors contributing to the observed rise in Gonorrhoea in YP, and strategies to reduce infection rates.

Category: Viral sexually transmitted infections

P230 WITHDRAWN

P231 WITHDRAWN

P232 CASE REPORT: AN HIV POSITIVE PATIENT WHO HAS TWICE SPONTANEOUSLY CLEARED HEPATITIS C INFECTION

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10.1136/sextrans-2015-052126.274

Introduction A 26% spontaneous clearance rate of Hepatitis C (HCV) in HIV negative populations is estimated, although the extent may be higher. Spontaneous clearance rates in HIV/HCV co-infected populations are lower. We report an HIV positive patient who has twice spontaneously cleared acute HCV infection.
Case report A 43 year old MSM diagnosed HIV positive in 1999 (WT virus, Nadir CD4 300) had evidence of past resolved Hepatitis A and B at time of HIV diagnosis. He commenced antiretroviral therapy (ARVs) in 2001 achieving virological suppression (VL 40). Hepatitis C was diagnosed in 2008 on tests prompted by raised LFTs: HCV antibody positive, HCV RNA 55 iu/ml, genotype not available. HCV antibody was negative 12 weeks earlier. Seroconversion was asymptomatic and associated with a transient rise in serum alanine transaminase (peak 189). HCV RNA was undetectable 2 weeks later and remained so for 5 years. He re-presented with symptomatic acute Hepatitis C in 2013: HCV RNA 59258 iu/ml, genotype 1, ALT 519. ALT normalised and HCV RNA fell to the limit of sensitivity of the assay (12 iu/ml) within 2 weeks. HCV RNA remained negative 1 year later. Re-infection occurred during a self imposed ARV treatment interruption and was associated with injecting drug use, high sexual risk taking behaviour and co-infection with bacterial STIs. Acute HCV was diagnosed within 4 weeks of restarting ARVs.
Discussion As spontaneous clearance of HCV in HIV/HCV co-infected individuals is less common than those mono-infected, it is of interest that this patient has twice spontaneously cleared HCV.

P233 IS ROUTINE BLOOD MONITORING FOR SUPPRESSIVE HERPES TREATMENT NECESSARY?

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10.1136/sextrans-2015-052126.275

Background There is no published evidence on the need for routine blood monitoring for people requiring daily oral acyclovir. Locally clinical practice differred between services. Dose reduction in moderate to severe renal impairment is recommended. Guidance for intravenous administration recommends measuring full blood count (FBC), renal (U&E) and liver function (LFTs) periodically.

Methods In 2013 we reviewed clinical notes coded for herpes suppression to establish whether BASHH and local standards were met for management of herpes suppression and routine blood monitoring.
Results 41 cases were reviewed. 32 (73%) had baseline blood tests. Of these 6/32 (19%) had abnormal results: 2 raised LFTS, 2 low estimated Glomerular Filtration Rate (eGFR), 2 low neutrophils – all resolved on repeating except one with fluctuating neutropenia. 19/32 (47%) had bloods repeated at our service and additional 16% advised to attend GP. Only 1/19 (5%) had normal baseline bloods, low eGFR at one month, but normal at 2 months.

Abstract P233 Table 1 Auditable standard results

Standards (Target: BASHH or *local)	Achieved
Virological confirmation (100%)	98%
Viral typing (100%)	90%
Baseline FBC, U&E, LFT (*100%)	73%
Offer letter to GP (*100%)	78%
Letter to obstetrics if pregnant (*100%)	100%

Discussion 19% of those tested had blood abnormalities at baseline, but only 3% had on-going abnormalities likely affected by acyclovir. We recommend checking U&E, LFT and FBC at baseline. If normal no further monitoring is needed. If mildy abnormal repeat but continue aciclovir. If significantly low eGFR, leucopenia or elevated LFTs either dose reduce or stop acyclovir and investigate.

P234 GLOBAL ESTIMATES OF PREVALENT AND INCIDENT HERPES SIMPLEX VIRUS TYPE 2 INFECTIONS IN 2012

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10.1136/sextrans-2015-052126.276

Background/introduction Genital herpes, usually caused by infection with herpes simplex virus type 2 (HSV-2), can cause substantial morbidity in the form of painful genital ulcers in infected adults and adolescents, as well as significant psychosocial morbidity. Neonatal herpes, acquired during delivery from mothers with genital herpes, is rare but often fatal. Additionally, HSV-2 increases susceptibility to, and transmissibility of, HIV. The global burden of HSV-2 was last estimated for 2003.
Aim(s)/objectives To present new global HSV-2 estimates for 2012 for females and males aged 15–49 years.
Methods Literature review of HSV-2 prevalence studies worldwide since 2000, followed by fitting of a model with constant HSV-2 incidence by age to pooled HSV-2 prevalence values by WHO region, age and sex. Prevalence values were adjusted for test sensitivity and specificity.
Results In 2012, we estimate that 417 million people aged 15–49 years (range: 274–678 million) had existing HSV-2 infection world-wide: a global prevalence of 11.3%. Of those infected, 267 million were women. Also in 2012, we estimate that 19.2 million (range: 13.0–28.6 million) individuals aged 15–49 years were newly-infected with HSV-2: 0.5% of all individuals globally. Prevalence was highest in Africa (31.5%), followed by the Americas (14.4%). Burden of numbers infected was highest in Africa. However, despite lower prevalence, South-East Asia and Western Pacific regions also contributed large numbers to the global totals because of large population sizes.
Discussion/conclusion The global burden of HSV-2 infection is large, highlighting the critical need for development of vaccines, microbicides and other prevention strategies against HSV-2.

P235 PREVALENCE AND RISK FACTORS ASSOCIATED WITH ORAL HPV AMONG STI CLINIC ATTENDEES

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10.1136/sextrans-2015-052126.277

Background Oral human papillomavirus (HPV) infection increases the risk of a sub-set of head and neck cancers. The epidemiology of oral HPV infection is not well understood.
Aim To describe the prevalence and risk factors for oral HPV infection amongst STI clinic attendees.
Methods Participants were recruited from a STI clinic, completed a risk factor questionnaire and provided oral samples for HPV DNA testing by a highly sensitive PCR using the SPF-10 broad spectrum primers. Overall positivity (prevalence) for any HPV was calculated. Chi-square test was used to determine the association between risk factors and oral HPV-positivity.
Results Ninety-eight participants (50 men and 48 women) with a median age of 29 (range 20–52 years) were recruited. Overall, 67.4% (66 of 98) participants were positive. All participants reported a history of oral sex. Participants from a non-White ethnic group were more likely to be oral HPV-positive than Whites (63.1% vs. 92.9%, $p = 0.03$) and those who engaged in open mouth/deep kissing in the last 24 h were also more likely to be oral HPV-positive than those who did not (86.2% vs. 59.7%, $p = 0.01$). No statistically significant associations were found with recent history of oral sex, smoking, alcohol and cannabis use, or lifetime number of sexual partners.
Conclusion Oral HPV infection is common among STI clinic attendees. It is unclear whether these are transient oral HPV infections or true persistent infections with oncogenic potential. Our limited data suggest that recent open mouth/deep kissing behaviour is associated with transmission of oral HPV.

P236 IS ANNUAL CERVICAL CYTOLOGY IN HIV POSITIVE WOMEN JUSTIFIED IN THE ERA OF HPV TESTING? A 2-YEAR STUDY IN A DISTRICT GENERAL HOSPITAL

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10.1136/sextrans-2015-052126.278

Background/introduction As per guidelines all HIV positive women have annual cytology irrespective of their CD4 count, viral load, and antiretroviral therapy. Smear tests are often cumbersome and most patients dislike annual smears. There is a lot of administration and cost involved in screening these women on an annual basis.
Aim(s)/objectives We looked at cervical cytology results of our HIV positive cohort for 2 years in the era of HPV testing and found some interesting results.
Methods Data collected on excel sheet and analysed.
Results Total of 153 cases was reviewed for over 2 years. 123/153 had negative HPV test. 30/153 had positive HPV test.

Negative cytology with HR HPV detected	5/30	Referred for colposcopy
Mild /low grade dyskaryosis	17/30	Repeat smear in 6 months.
Borderline changes	6/30	3/6 HR HPV detected were referred for colposcopy, 3/6 HPV not detected had repeat smear in 6 months.
Moderate dyskaryosis	1/30	HR HPV detected, referred for colposcopy
Severe dyskaryosis	1/30	HR HPV detected, referred for colposcopy

Out of the 30 with HR HPV: 5/30 was not on ARV. 25/30 on ARV had HIV VL <50 cpm. Age range from 28–62 years. 22/30 was Black African. 6/30 was white UK.

Conclusions Women with HIV infection who engage in medical care are usually on antiretroviral therapy and are virologically suppressed. The patients with HR HPV were followed up with colposcopy and continue to have annual smears. Patients with negative smear results who are HR HPV negative can be screened as per the normal population.c

P237 HEPATITIS C AMONG MEN WHO HAVE SEX WITH MEN IN GREATER MANCHESTER – THE BASELINE SURVEY

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10.1136/sextrans-2015-052126.279

Background/introduction The number of HIV affected men who have sex with men (MSM) co-infected with hepatitis C (HCV) continues to rise, driven by high risk sexual practice.

Aim(s)/objectives To determine HCV burden and associated risk behaviours among MSM in Greater Manchester.

Methods Between April and October 2014, all MSM attending four GUM clinics were asked to complete a risk assessment questionnaire and HCV screening was offered.

Results There were significant differences in risk behaviour between HIV positive and HIV negative MSM ($p < 0.05$). Certain risk behaviours were strongly associated with HCV acquisition including: unprotected anal sex, sex with known HCV partners, fisting, group sex, 'slamming' and recreational drug use ($p < 0.002$).

Discussion/conclusion Our study shows HIV positive MSM have significantly different sexual behaviour which may explain the higher HCV burden. However, HCV was found in HIV negative MSM engaging in high risk sexual practices. All MSM attending sexual health clinics must have a risk assessment and HCV screening should be offered based on the risk. Further studies are warranted to look at the difference in HCV transmission according to the HIV status.

P238 HEPATITIS C TESTING IN MSM – ARE WE ASKING THE RIGHT QUESTIONS?

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10.1136/sextrans-2015-052126.280

Background Concern regarding high rates of hepatitis C infection in sub-groups of MSM may warrant targeted testing.

Aim We examine whether we routinely collect the necessary information from MSM to identify those at risk and target hepatitis C testing, and assess whether our concerns about emerging risk factors for hepatitis C are implicated in new diagnoses in our cohort.

Methods Notes audit of all MSM GUM attendances during November 2013 assessed documentation of fisting, rectal bleeding with sex, group sex, and drug use, as well as hepatitis testing. Notes of all patients coded for hepatitis C infection during 2011–2013 were examined to assess risk factors for hepatitis C infection.

Results 147 MSM attendances were reviewed. The proportion of men asked about specific risk factors was: drug use (18%), rectal bleeding (1%), group sex (1%), fisting (1%). 8% MSM had hepatitis C screens, none with traditional risk factors. Over 3 years, 46 patients were coded for hepatitis C. 34% of these were new infections. 33% were HIV positive, 48% had injected drugs (41% no documentation), 22% had hepatitis C positive partners, 11% were sex workers.

Discussion/conclusion Drug use and high risk sexual practices were not always fully recorded in our sample. Testing rates were low and did not seem to relate to identifiable risks. We identified few cases of new infection, largely limited to patients with traditional risk factors. It is not clear if better recording of risk factors would lead to increased Hepatitis C testing or diagnosis.

Category: Women and children

P239 DOES SERVICE INTEGRATION IMPROVE THE SEXUAL AND REPRODUCTIVE HEALTHCARE OF HIV POSITIVE WOMEN?

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10.1136/sextrans-2015-052126.281

Background NHS Lothian Genitourinary Medicine (GUM) and Sexual and Reproductive Healthcare (SRH) services integrated in June 2011. Contraceptive use, pregnancies and uptake of annual cervical cytology were audited in a cohort of HIV positive women pre- and post-integration of services.

Aims To assess whether the SRH of HIV positive women has improved after integration of services, and to guide further service improvements.

Methods Case notes and electronic data recording system entries were interrogated for the 5 years preceding integration of services and the 3 years following integration.

Results *Contraception:* Pre-integration 24.9% of 70 women with contraceptive needs were on effective prescriptions. Post-integration this proportion rose to 39.3% of 74 women.

Pregnancies: In the 5 years pre-integration 32 women had 42 pregnancies. 47.6% of these pregnancies were unplanned (UP). In the 3 years post-integration 13 women had a total of 18 pregnancies, 50% were UP pregnancies.

Cervical cytology: Pre-integration 47.3% of those eligible had a cervical cytology result documented within the last year, which improved to 74.6%.

Conclusion Contraceptive provision improved after service integration although there remained fewer than 40% of women using a suitable method. Despite this improvement, UP pregnancy rates did not fall significantly. In a cohort of women attending an integrated service regularly, who are known to have an infection which can be vertically transmitted, it is

disappointing that rates are comparable to those seen in the general population. The proportion of women who had cervical cytology in the last year has improved from 47.3% to 74.6%.

P240 EVALUATING CURRENT CONTRACEPTIVE PRACTICE IN WOMEN ATTENDING TERMINATION OF PREGNANCY SERVICES IN GLASGOW

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10.1136/sextrans-2015-052126.282

Background/introduction Despite free contraception in Scotland, over 12,000 terminations of pregnancy (TOP) are carried out annually at great financial cost.
Aim(s)/objectives To quantify methods of contraception in women presenting with unintended pregnancy at a large urban integrated sexual health unit, to identify reasons for failure.
Methods A retrospective case note review of a random sample of 100 women attending termination referral services between October 2013–March 2014.
Results Of attendees, mean age was 26 years. 38% had used male condoms. 35% "no contraception". 25% Oral contraceptive pill. 24% of condom users and 43% of COCP reported imperfect use. Additionally, 9% fell pregnant despite reported use of emergency contraception. 45% had undergone at least one therapeutic termination previously, of these: 22% reporting no use of contraception at time of conception. 4% no contraception ever. 44% of repeat attenders and 28% of whole sample reported using LARC methods in the past. 63% of women stated intention to undertake a LARC method post-procedure, however it is not clear if these were implemented.
Discussion/conclusion Large numbers of repeat TOPs suggests problems with uptake of reliable contraception post-procedure. Counselling at initial consultation – especially for repeat attendees; specific post-termination clinics and support; interventions and education targeted at high risk groups; and advocated use of LARC should reduce repeat procedures. LARC methods of contraception should continue to be encouraged in all females for primary prevention given their extreme effectiveness. Future studies of the actual uptake versus stated intention to use LARC may be insightful.

P241 CONTRACEPTION AND CONDOM USE IN HIV POSITIVE WOMEN

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10.1136/sextrans-2015-052126.283

Background/introduction The British Human Immunodeficiency Virus Association has published standards for the care of people living with HIV. Condom use is important in preventing transmission of HIV. Preconception care and contraceptive provision allow HIV positive women to plan pregnancy and reduce the risk of vertical transmission.
Aim(s)/objectives To ascertain whether HIV positive women in our service were using effective contraception to prevent pregnancy as well as consistent condom use.
Methods The notes of 61 female patients attending for regular HIV management within our health board were identified and reviewed. The data collected included documented condom use, contraceptive use and whether the method interacted with their treatment.
Results 57% of women were documented as using contraception, the intrauterine system being the most widely used. 13% did not need contraception due to the menopause or hysterectomy whilst 11% were documented as not currently sexually active. 12 women used condoms alone as contraception. All women on antiretroviral treatment were using appropriate forms of contraception. 21 women did not have documentation of condom use although 9 of those women were recorded as not having a partner.
Discussion/conclusion This audit has highlighted that our service requires better documentation of condom usage. Assumptions should not be made that people without partners are not sexually active. Contraception uptake was well documented with appropriate methods used whether on treatment or not. Due to the high failure rate of condoms, emphasis should be made on using them in conjunction with other forms of contraception.

P242 STILL CHILDREN

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10.1136/sextrans-2015-052126.284

Background/introduction Our GUM clinic holds an integrated young person's clinic (YPC). We have used a proforma for under 16s. In 2014 a national proforma for identifying risk of child exploitation, "*Spotting the Signs*" was published. We decided to expand the use of the proforma to <18s.
Aim(s)/objectives To assess whether expanding the use of the young person's (YP) proforma would identify risk factors and vulnerabilities in 16–17 year olds that may have otherwise been missed.
Methods Casenote review of 50 consecutive YP aged 16–17 attending a YPC.
Results 45(90%) were female. YP were at high risk of sexually transmitted infection (STI)–9(18%) past history of STI, 15 (30%) last sex with a casual partner, 15(30%) >1 partner in last 3 months, 38(76%) no or inconsistent use of condoms. 11/37(30%) screened were diagnosed with an STI (chlamydia 5, PID 4, warts 1, herpes 1). All reported that they felt able to say "no" if they did not want sex, including one who attended following sexual assault and 5 with a history of unconsensual sex. Other than those, no cases of sexual exploitation were identified; however risks/vulnerabilities were identified in many–19(38%) mental health problems, 21(42%) self-harm, 41 (82%) regular alcohol and 8(16%) drug use, 12(24%) low self-esteem. 12 (24%) had had a previous attendance when the proforma was not used.
Discussion/conclusion Expanding the YP proforma to <18s resulted in identifying a significant number of vulnerabilities and risk factors (mainly self-harm and low-self-esteem) for sexual exploitation and STIs that might otherwise have been missed.

P243 "IN AND OUT" – MEASURING OUTCOMES FOR PREGNANCY PREVENTION IN FEMALES ATTENDING SEXUAL HEALTH CLINICS

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10.1136/sextrans-2015-052126.285

Background/introduction Our level 3 GUM clinic has held an integrated young person's clinic (YPC) since 2008. As well as STI testing, we provide all methods of contraception except intrauterine devices, for <25s. Maximising the uptake of LARC is recommended as a method of preventing unplanned pregnancy. Previous audits of females attending for contraception have shown that 100% are offered LARC, but have not included females attending the YPC for other reasons.
Aim(s)/objectives To assess the utility of contraceptive methods of female patients attending and leaving the YPC, as an outcome measure for the effectiveness of contraceptive interventions.
Methods Prospective audit of 100 consecutive females attending the YPC from October 2014.
Results The average age was 19 (14–24). 77(77%) attended purely for contraception, 11(11%) for a sexual health check and 12(12%) for both. 15/17(88%) of those not using contraception and 18/21(86%) of females using condoms left the clinic with a form of hormone contraception [19/38(50%) LARC]. On arrival 28(28%) used oral contraception/Evra and on leaving 42(42%). On arrival 33(33%) had LARC and on leaving 48(48%) had LARC. LARC was offered to all females not already using it, except 2 with complex medical conditions. The commonest reasons for declining were being happy with their current method-17(17%) and fear of side effects-11(11%).
Discussion/conclusion The SRHAD proforma used by sexual health clinics only records contraception supplied. Contraception in/out is a better outcome measure of the prevalence of LARC use in a clinic's attendees, and an indicator of holistic sexual healthcare in an integrated YPC.

P244 CHILD SEXUAL EXPLOITATION – REVIEW OF INFORMATION SHARING AND IDENTIFYING PATIENTS AT RISK

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10.1136/sextrans-2015-052126.286

Background/introduction We are a community based, multidisciplinary team providing sexual health care for 8,000 under 20s that attend our service yearly. Child Sexual Exploitation (CSE) is an increasingly recognised problem that affects young vulnerable people across the UK. Information sharing between agencies is an important factor in identifying young people who are involved in CSE and in order to improve our practice, we retrospectively reviewed case notes of those identified as vulnerable to CSE by other agencies.
Aim(s)/objectives To identify: was information shared when a risk of CSE was identified during the sexual health consultation? What is the prevalence of strong and warning signs of CSE in this population of young people attending sexual health services?
Methods Retrospective case note review using our health authority tool for identifying CSE risks.
Results 76 of the136 young people identified had attended our service. 39/76 (51%) had at least one strong indicator for CSE. 36/39 nine were known to social work. 38/39 had documented information sharing. 11/76 (14%) had at least one warning indicator and 26/76 (35%) had no identifiable CSE risk factors. 7/26 had information shared with social work.
Discussion/conclusion Information sharing occurred for almost all patients identified with a strong risk factor for CSE. 49% of the young people identified by other agencies as at risk did not disclose information that strongly indicated CSE. Incorporation of the BASHH spotting the signs proforma and training to further increase staff awareness is being developed.

P245 A PRAGMATIC PATIENT PATHWAY ENSURING APPROPRIATE SAFEGUARDING DECISIONS FOR CHILDREN WITH GENITAL WARTS

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10.1136/sextrans-2015-052126.287

Background/introduction Children found to have genital warts may present to doctors of various disciplines. The experience and knowledge of these doctors in the diagnosis and management of genital warts, and the need to assess for possible sexual abuse and other sexually transmitted infections (STIs) is variable. The authors have all been contacted for advice regarding the management of these children. In order to streamline this process and ensure that all children are appropriately assessed we developed a clinical algorithm.
Aim(s)/objectives To establish a pragmatic clinical algorithm incorporating safeguarding decisions for the management of children with genital warts.
Methods A group of paediatric, GUM and forensic physicians reviewed the evidence and relevant UK guidelines, consulted with other experts in the field and drafted an algorithm for the management of children with genital warts.
Results An initial algorithm was piloted by the authors and colleagues and sent to authors of relevant UK guidelines for their opinion. The algorithm was then finalised and is now in use in our region. It is presented as a simple flowchart.
Discussion/conclusion Developing this algorithm was complicated by differing views of experts in the field and the unfamiliarity of some doctors other than GUM or forensic physicians in performing genital examinations in children and taking the required tests. We have found this algorithm to be a useful framework for clinical decision making, to support safeguarding decisions and to ensure that the required steps are taken when assessing children with genital warts.

P246 SURVEY OF IMPLANT REMOVALS IN A YOUNG PEOPLE'S SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.288

Background/introduction A trend for young people (YP) to abandon the contraceptive implant because of intolerable side effects has been noted. YP aged 21 and under attend our Sexual Health (SH) services in London for implants at a rate of 3 inserted to every 2 removed. Replacement of a removed implant is rare: 1 replacement implant to 32 removed. We decided to investigate our clinic population for this trend.
Aim(s)/objectives To identify profile of YP who have implant removals, reasons for removal and formulate on-going support mechanisms.
Methods Staff completed questionnaires on 20 implant removals to ascertain YP profiles and reasons for remova.

Results

Age at removal	Range 15–21 yrs, Mean 18.5 yrs, Median 18.5 yrs
Length of use	Mean 10.5 months
Inserted Pulse	10
Identified number of reasons for removal:	**7**
Unscheduled bleeding	11
Other reasons for removal	18 total
Weight gain	5
Mood changes	6
Bloating	2
Headaches	3
Nausea	2
Miscellaneous	13
Received bleeding management	5
Willing to accept further bleeding management	0
Requests for replacement implant	0

Discussion/conclusion Unscheduled bleeding is the most common reason for premature removal of implants, however many reported multiple reasons. All removals except one required ongoing reliable contraception, but none were willing to reinsert implant. These clients require support to continue this very effective form of contraception: future support includes: Identify who may require monitoring; Stress choices at outset; Offer bleeding management at early stage; Follow up new insertions at 6/52 via telephone support from Health Advisor or Nurse. Ongoing work will include monitoring and surveys on post TOP removals.

P247 QUALITY OF LIFE AND SEXUAL FUNCTION AMONGST WOMEN WITH PERSISTENT GENITAL DISCHARGE OR DERMATOSES

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10.1136/sextrans-2015-052126.289

Background Existing data on the effect of genital discharge and dermatoses on the quality of life (QoL) and sexual function (SF) in women with genital complaints are limited.
Objectives To study the impact of our specialist clinic for recurrent genital problems on QoL and SF using two validated questionnaires: dermatology life quality index (DLQI) and female sexual function index (FSFI).
Methods All women attending this specialist clinic during 2013 were invited to complete both DLQI and FSFI. Questionnaires were resent six months later or completed at follow-up attendance. Paired questionnaires were analysed using Wilcoxon-signed-rank tests.
Results We received 143 responses: 99 dermatological complaints and 44 discharge complaints. Both complaints have a detrimental effect on QoL (mean ± SD quality of life scores 8·4 ± 6·6, moderate effect on QoL vs published general population score between 0 and 1 in validation studies). SF was also impaired (score 19.6 ± 6.9, vs published general population mean score 30.5 ± 5.29). 13 patients fully completed DLQI pre and post clinic intervention; there was significant improvement in DLQI scores (median pre-intervention vs post-intervention scores, interquartile range (IQR): 15 (12–18) vs 8 (6–12), $P = 0.013$). FSFI scores did not significantly improve (18.55 (16.5–22.5) vs 18.5 (14.0–22.7), P = 1.000).
Discussion/conclusion Both QoL and SF are impaired in many women presenting with recurrent genital complaints. Appropriate assessment and management by senior physicians can significantly improve QoL in these women supporting the role of specialist clinics. There remains significant impairment to SF, warranting research into affordable interventions.

P248 SENSITIVITY OF THE AMSEL'S CRITERIA COMPARED TO THE NUGENT SCORE IN ABSENCE AND IN PRESENCE OF *TRICHOMONAS VAGINALIS* (TV) AND/OR *CANDIDA* SPP AMONG WOMEN WITH SYMPTOMATIC VAGINITIS/ VAGINOSIS

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10.1136/sextrans-2015-052126.290

Background/introduction In a multicenter clinical trial funded by BD, we observed less accurate clinician diagnosis of bacterial vaginosis (BV) based on clinical observations when *Trichomonas vaginalis* (TV) and/or *Candida* spp. were also detected by the trial Reference Methods than when only BV was detected.
Aim(s)/objectives To determine the sensitivity of each criterion and of the overall Amsel's criteria (3/4 criteria met), the results of the Amsel's corresponding to the sub-population of specimens that gave a Nugent score of 7–10 were analysed.
Methods Following informed consent, women with symptoms of vaginitis/vaginosis were included in the trial. The four Amsel's criteria and the Nugent score were performed. Evaluation for trichomoniasis by wet mount and culture (InPouch™ TV, Biomed) were performed. *Candida* colonies were isolated (BBL™ Sabouraud Dextrose Agar, Emmons and BBL™ CHROMAgar™ Candida plate, BD) and identified by ITS-2 bi-directional sequencing (Accugenix®).
Results In total, 269/497 (54.1%) specimens gave a Nugent score of 7–10. Amongst them, TV and/or *Candida* spp. were found in 100 specimens (37.2%). The sensitivity of clue cells, amine test, vaginal pH, BV vaginal discharge, and overall Amsel's criteria in absence of TV and/or *Candida* spp. was 86.3%, 82.7%, 91.1%, 71.0%, and 84.6% respectively. In presence of TV and/or *Candida* spp., the sensitivity was 63.6%, 64.0%, 75.0%, 42.0%, and 60.0% respectively (p values 0.0009 for all comparisons).
Discussion/conclusion The sensitivity of the Amsel's criteria in women with BV decreases when TV and/or *Candida* spp. are present. The BV vaginal discharge is the least sensitive criterion.

P249 SO WHAT DO WOMEN WANT – ESTABLISHING A WOMEN'S SEXUAL HEALTH SERVICE

Emma Collins*, Michelle Hawkins. *BSUH NHS Trust, Brighton, UK*

10.1136/sextrans-2015-052126.291

Introduction Patient and public feedback has highlighted the need for targeted sexual health services for women in our city.

Women who have sex with women (WSW) were reluctant to attend services due to perceptions of low risk and discrimination, and valued the choice of a women-only service).

In 2012 a women's clinic opened, offering a range of sexual health and contraception services. Staffed by female HCPs and receptionists, the service has been well received by women. Plans for a women-only waiting area proved challenging within the confines of environment and patient activity.

Aim(s)/objectives To assess patient experience of the women's clinic, including that of mixed sex versus female only waiting areas.

Methods An anonymous patient experience questionnaire distributed 3rd–17thApril 2014. Women were asked their age, sexual orientation, previous experience of services and their views on accessing integrated contraception and sexual health care. Data was collated and entered into an excel database.

Results Questionnaires were received from 43 women (36 fully completed); Majority (n = 21, 50%) 26–35 years. 33 (77%) WSM, 3 (7%) WSW; 7 (16%) did not answer. 28 (66%) had accessed other sexual health/ contraception services within 3 years. 3 (6%) preferred female only waiting areas, with 40 (94%) wanting a choice, or stating that they had no strong feelings.

Discussion Assumptions about acceptability of single-sex waiting areas did not match the majority of patients' views. WSM and WSW accessing the service valued the choice of mixed or single sex waiting areas.

P250 SEXUAL HEALTH INFORMATION AND SERVICES: THE VIEWS AND EXPERIENCES OF 14 TO 22 YEAR OLDS

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10.1136/sextrans-2015-052126.292

Background/introduction Young people are not always consulted about their sexual health information and service needs.

Aim(s)/objectives The authors sought to capture young people's views and experiences of sexual health information and services in a specific geographical area.

Methods An online survey was published on survey monkey between 4 and 16 December 2014. It was promoted via social media, youth groups and Lesbian, Gay, Bisexual and Transgender (LGBT) organisations. 207 responses from young people aged between 14 and 22 were analysed.

Results 50% of respondents were female. Of 190 stating sexuality, 12% may be gay or bisexual. Only 13% had attended sexual health classes that met all their sexual health needs. Young people reported getting sexual health information from TV programmes and websites. Young women were more likely to get information from family members than young men. Most young people knew where they could get condoms, pregnancy tests and emergency contraception. 85% did not know about PEP (Post Exposure Phrophylaxis) for HIV. 30 young women had talked to a health professional about contraception, most commonly the pill and implant. Young people want sexual health services to be open in the evenings and weekends, the most common combination was Monday evening, Friday evening, and Saturday afternoon.

Discussion/conclusion The sexual health information needs of young people are not being met in education settings. More information about PEP is needed, especially for young gay and bisexual men. Sexual health services should have extended opening hours leading up to, during and after weekends.

P251 TREATMENT DILEMMA OF CHLAMYDIA IN PREGNANCY

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10.1136/sextrans-2015-052126.293

Background Drug hypersensitivity reactions are immunological responses to medications. An accurate understanding of the type of antibiotic hypersensitivity reactions is crucial in the decision making process of alternative antibiotic usage versus desensitisation.

Clinical presentation A 25-year old female, twenty-four weeks pregnant, with dysuria was diagnosed with Chlamydia. She had asthma, which was treated with inhalers. She gave a history of reaction to penicillin and an episode of collapse and rash to erythromycin. Effective treatments for Chlamydia are azithromycin, erythromycin, amoxicillin and doxycycline. The latter is contraindicated in pregnancy and erythromycin and amoxicillin were contraindicated because of this patient's history. There is small risk of cross reactivity between azithromycin and erythromycin, so a desensitisation protocol was drawn up by the immunologist. The patient was counselled regarding the possibility of a reaction even to small doses of azithromycin and the possibility of an anaphylactic reaction needing adrenaline, which could precipitate preterm labour. She was admitted on the ward and given azithromycin in titrating doses, which was tolerated well without any problems. The repeat chlamydia test following treatment was negative.

Discussion There are limited therapeutic choices for treatment of various sexually transmitted infections in patients with allergies particularly in pregnancy. These patients will need desensitisation under an immunologist with careful monitoring. If a patient with a reported allergy is deemed not allergic or if the allergy is simply an expected side effect, the medical record should be updated to reflect this change along with educating the patient.

P252 TILL DEATH DO US PART: MARRIAGE, AFRICAN-BORN WOMEN AND HIV PREVENTIATION IN THE UNITED KINGDOM

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10.1136/sextrans-2015-052126.294

Background/introduction Recent studies from Sub-Saharan Africa, most especially Southern Africa, reveal a shocking trend in HIV transmission with married couples recording the biggest percentage of new infections per annum. Hence the mode of transmission as far as HIV is concerned has been evolving and the previously so called 'low risk' unions are no longer as safe as previously thought, most especially for women. UK literature shows that the trend of HIV in Black-African population mirrors that in Africa. Making of culturally sensitive and therefore effective policies and interventions for this particular group calls for a good in-depth understanding and insight into experiences and strategies that persists and those that newly emerge for married African-born women when they immigrate into UK.

Aim(s)/objectives The aim of this study was to explore experiences and strategies of married African-born women who are living in the United Kingdom in prevention of HIV.
Methods Eighteen in-depth Interviews were conducted with married African-born women who were aged between 25 to 55 years old in three Scottish cities: Aberdeen; Edinburgh; and, Glasgow.
Results Women's reports suggest a false sense of security amongst married women in regard to HIV prevention. Contrary to the daily exposure to the lived realities of HIV in Africa, HIV is rarely mentioned in media or discussed by health professionals. Condom use and asking husbands to get HIV tested was deemed unnecessary and therefore often neglected.
Discussion/conclusion Policies and interventions for HIV prevention amongst married African-born women should transcend multiple levels: individual-level; couple-level; and, structural-level.

P253 REGIONAL AUDIT OF TESTING CHILDREN OF HIV POSITIVE MOTHERS

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10.1136/sextrans-2015-052126.295

Background In 2009, the "Don't forget the children" report recommended that all new HIV-positive patients attending adult HIV services should have any children identified, tested and the information clearly documented. In our clinic, HIV diagnosis in a child was delayed due to lack of a robust testing protocol despite regularly engaging with the mother for her care. We aimed to survey our clinic's testing practice before and after publication of this report to assess impact.
Method A retrospective case note review on all HIV positive women registered at the Solent adult HIV service. The population will be divided into 2 groups: (a) pre guidelines (n = 81), and post guidelines (n = 61). Details of children, their ages, country of residence, testing status, outcomes and timescales were recorded.
Results

	Pre-guidelines (2000–2009) n = 81	Post-guidelines (2010–2014) n = 61
Number of children <18, UK resident, at risk	36	33
Number of children for whom HIV testing was discussed and documented in maternal notes	22 (61%)	33 (100%)
Testing initiated by HIV service	10	15
Time scale for children to be tested (range)	3 months – 9 years	3 months – 3 years

Conclusion Testing of children at risk of HIV has significantly improved in our service since the publication of "Don't forget the Children". However this audit identified some children who continue to remain untested or status unconfirmed. We have implemented a robust protocol to chase up outcomes of children tested outside of HIV service and to proactively negotiate testing when parents initially decline consent. Since January 2012, Southampton has been integrated with 3 other clinics to form Solent Sexual Health Service. We plan to extend this retrospective audit to include HIV positive women attending 3 other clinics, which may result in identification and testing of more children at risk.

P254 SAFEGUARDING CHILDREN IN SEXUAL HEALTH SERVICES – A GROWING CONCERN

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10.1136/sextrans-2015-052126.296

Background Additional focus on child sexual exploitation (CSE) and high profile safeguarding cases within the media has impacted on workload within sexual health services. Our trust has established pathways for sharing information about the most vulnerable children in the form of named nurse (for safeguarding children) notifications (NNN). These facilitate the triangulation of information and senior review of cases. Following integration in 2011 we have emphasised the need for all clinical staff working across different sites to recognise children at risk and notify cases.
Aim To quantify the NNN made from our integrated service as a measure of safeguarding children workload.
Methods Numbers of safeguarding referrals in the form of NNN initiated by our service over 3 years were obtained from the NNN database.
Results

Year	January–March	April–June	July–September	October–December	Total
2012	0	0	2	1	3
2013	3	4	6	7	20
2014	11	19	18	23	71

10 database entries were undated: 5 closed in 2012; 5 in 2013.
Discussion The workload in managing children at risk has increased as demonstrated by the large rise in NNN. It is important that the additional workload falling upon teams is recognised and particularly the disproportionate burden falling upon health advisors who may be supporting the young people in addition to advising colleagues. The marked increase may have resulted from community staff gaining more experience in recognising the signs of children in need. Further training, supervision and the use of a standardised proforma across all sites may also have contributed.

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