likely to have a successful response by 6 months in primary syphilis. This study also demonstrates the need for strategies to address the large number of patients lost to follow-up.

## P66 TESTING FOR *TRICHOMONAS VAGINALIS* (TV) BY TRANSCRIPTION MEDIATED AMPLIFICATION (TMA). AN EVALUATION IN A LARGE CITY CLINIC

doi:10.1136/sextrans-2012-050601c.66

M Lawton,* G Schembri, M Kingston. *Manchester Royal Infirmary, Manchester, UK*

**Background** Trichomonas is worldwide, the commonest curable STI. While it's prevalence in the UK is less than other areas of the world, it remains a common cause of vaginal symptoms in women. Although not routinely tested in men it can be a cause of discharge and dysuria. It may be asymptomatic in both sexes. There is debate about the significance of TV infection, over and above it's symptomatology. The majority of centres use wet-film microscopy and/or culture for the detection of TV. The sensitivity of wet-film is recognised to be low. Culture has been considered the gold standard for TV detection, but is slow and costly.
**Methods** Symptomatic female patients and men with recurrent/persistent NSU were tested for TV using the same sample as the Chlamydia/gonorrhoea specimen. They were analysed using the Gen-Probe APTIMA TV assay in addition to the usual Chlamydia/gonorrhoea AC2 assay. Patients symptomatic of discharge had wet-film microscopy done as per standard clinical practice. Demographic data and symptomatology were recorded. Comparison was made between results from TMA and wet-film.
**Results** 1457 patients were tested for TV using TMA. Almost all (97%) were women. The overall prevalence for Trichomonas, Chlamydia and gonorrhoea via TMA was 3%, 8%, 1% respectively. TMA identified significantly more cases of TV compared to wet-film (41 vs 20, p=0.009). The prevalence of TV was significantly higher than gonorrhoea (p=0.002). Subset analysis will be done prior to presentation.
**Conclusion** Testing for TV via TMA identified significantly more infections compared with the current method of detection. It's overall prevalence was much higher than gonorrhoea which is routinely screened for in asymptomatic patients. Given the same sample is used for analysis, it does not add any additional clinic time or discomfort to the patient. Cost effectiveness of using TV TMA, particularly in asymptomatic patients has not yet been evaluated.

## P67 ESTIMATION OF POPULATION COVERAGE OF CHLAMYDIA TESTING AMONG YOUNG ADULTS IN ENGLAND IN 2010

doi:10.1136/sextrans-2012-050601c.67

[1]A Nardone,* [2]C Robinson, [2]R Craig, [3]S Woodhall, [3]A Talebi, [4]C Mercer, [4]A M Johnson. *[1]Health Protection Agency; [2]National Centre for Social Research; [3]National Chlamydia Screening Programme, Health Protection Agency, London, UK; [4]Centre for Sexual Health & HIV Research, University College London, London, UK*

**Background** The National Chlamydia Screening Programme (NCSP), established nationally in England in 2008, aims to prevent and control chlamydia infection in young adults under 25 years of age through opportunistic community based testing.
**Aim** We wished to validate the NCSP estimates of chlamydia screening coverage in the target population of young adults by comparing to self-reported chlamydia testing among participants to the Health Survey for England (HSE).
**Methods** Chlamydia screening coverage is calculated centrally by combining the number of tests reported from three sources of data: NCSP; sexual health clinics; and laboratories. All three sources provide data by age and sex. HSE is an annual general health survey of a nationally representative selection of households in England. In 2010, questions on previous history of testing for chlamydia were asked of all 4259 individuals aged 16–54 who were interviewed. Analyses presented here are limited to the 725 young adults aged 16–24 years old.
**Results** In 2010, NCSP estimated that 2.2 million chlamydia tests were performed in England among young adults aged 15–24 years old, representing up to 33% of the target population (43% of females and 24% of males). In HSE 2010, 44% of females (177/402) and 27% of males (87/323) reported having ever had a chlamydia test. The proportion who reported having had chlamydia test in the last year was lower for both females (27%; 109/402) and males (17%; 55/323).
**Conclusion** We have demonstrated the progress made by NCSP in achieving high national levels of coverage. Estimated coverage rates in 2010 reported by NCSP were slightly higher than those recorded by HSE which may be in part due to the inclusion of those who have had repeat chlamydia tests. The data collected by HSE has proved a valuable source of data with which to monitor the progress of NCSP in achieving national targets for testing coverage and improve the delivery of the programme.

## P68 IMPROVING THE MANAGEMENT OF CHLAMYDIA IN NON-GUM SETTINGS: IT TO THE RESCUE!

doi:10.1136/sextrans-2012-050601c.68

C N C Zhou,* J Roberts, J Davies, M Longbone, G Dean. *Brighton and Sussex University Hospitals, Brighton, UK*

**Background** BASHH guidelines recommend all patients diagnosed with *Chlamydia trachomatis* (CT) should be given a detailed explanation of the condition, managed with appropriate antibiotics and have effective partner notification (PN). Patients tested in non-GUM settings may receive sub-optimal management. Following a 2008 audit highlighting several untreated CT cases in the Gynaecology Department (GD) we introduced a bespoke IT lab-link allowing daily downloads of results to GUM health advisers (HA).
**Objectives** To re-audit the management of females tested for CT in GD.
**Methods** We performed a retrospective database analysis of all CT tests requested by any of the 11 Gynaecology consultants from June 11 to January 12. Demographic and clinical details were extracted from a prospectively collected lab. database and clinic records. Results were compared with the 2008 audit. Fisher's exact test was used to compare differences between proportions.
**Results** 889 tests {864 (97.2%) negative, 16 (1.8%) positive, 9 (1%) not tested—incorrect swab} were requested by GD over 29 weeks. HAs were notified of 100% of results in real time. Median time from notification of positive results to patient contact was 1 day (range 1–60). Median time from positive result to treatment was 7 days (range 1–70). This compares to an upper limit of 168 days in the 2008 audit. Recommended antibiotics were used in all cases. PN outcomes improved from 31% to 75% (p=0.02) and untreated cases decreased from 38% to 18.7% (p=0.2) (see abstract P68 table 1).
**Discussion** Since the introduction of a referral pathway and automated IT lab-link, management of CT positive patients from GD has improved, in particular PN and proportion left untreated. GUM departments should have a clear pathway for the management of patients diagnosed with STIs in non-GUM settings.