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

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

O30 TREATMENT FAILURE IN MYCOPLASMA GENITALIUM AMONG GUM CLINIC ATTENDEES

[1]Katie Ovens*, [1]Elizabeth Cross, [2]Lucinda Rickwood, [3]John Reynolds-Wright, [4]Mohammed Osman Hassan-Ibrahim, [1]Suneeta Soni. *[1]Department GUM/HIV, Brighton and Sussex University Hospitals NHS Trust, Brighton, UK; [2]Brighton and Sussex Medical School, Brighton, UK; [3]St John's Hospital, NHS Lothian, NHS Scotland, Edinburgh, UK; [4]Department of Microbiology/Virology and Infection, Brighton and Sussex University Hospitals NHS Trust, Brighton, UK*

10.1136/sextrans-2017-053232.30

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

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

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

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

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

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

O31 EXPLAINING ETHNIC VARIATIONS IN STI DIAGNOSIS: RESULTS FROM BRITAIN'S THIRD NATIONAL SURVEY OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL-3)

[1,2]Sonali Wayal, [2,3]Gwenda Hughes, [1]Pam Sonnenberg, [3]Hamish Mohammed, [1]Makeda Gerressu, [3]Martina Furegato, [1,2]Catherine Mercer*. *[1]Centre for Sexual Health and HIV Research, Research Department of Infection and Population Health, University College London, London, UK; [2]Health Protection Research Unit in Sexually Transmitted and Blood-Borne Viruses, London, UK; [3]Public Health Enland, Colindale, UK*

10.1136/sextrans-2017-053232.31

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

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

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

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

O32 ETHNICITY AND SEXUAL BEHAVIOURS – THE ASSOCIATION BETWEEN ETHNICITY AND SEXUAL RISK BEHAVIOURS REPORTED BY HETEROSEXUAL MEN AND WOMEN IN A GUM SETTING

[1]Rachel Coyle*, [1]Ada Miltz, [1]Janey Sewell, [1]Andrew Phillips, [1]Andrew Speakman, [2]Daniel Ivens, [3]Tariq Sadiq, [4]Jyoti Dhar, [5]Stephen Taylor, [1]Lorraine Sherr, [6]Simon Collins, [7]Jonathon Elford, [1]Fiona Lampe, [1]Alison Rodger. *[1]Research Department of Infection and Population Health, University College London, London, UK; [2]Royal Free Hospital NHS Foundation Trust, London, UK; [3]St George's University Hospitals NHS Foundation Trust, London, UK; [4]Leicester Royal Infirmary, Leicester, UK; [5]Birmingham Heartlands Hospital, Birmingham, UK; [6]HIV i-base, London, UK; [7]School of Health Sciences, City University of London, London, UK*

10.1136/sextrans-2017-053232.32