

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

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

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

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

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

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

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

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

**Results**

**Discussion** Barriers to timely treatment included difficulty contacting patients, need to travel to a different service to obtain medication and difficulty arranging appointments at acceptable

times. Particular delays were noted in the management of syphilis. Clarification of each service's responsibilities with regard to contact tracing could improve partner notification rates. Even when HIV and sexual health services are not jointly commissioned, it is essential that both departments work together to develop robust pathways for the management of STIs identified in people living with HIV.

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

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

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

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

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

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

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