of recruiting new donors and stocks remain at critically low levels.

The histories we take in genitourinary (GU) clinics match closely with screening questions asked by the donation service and we wanted to explore whether there would be any value in utilising this similarity in promoting blood donation to our often young and otherwise healthy patient population.

Methods We conducted a prospective review of 100 consecutive patients seen during clinic, adding one extra question (regarding recent travel) to our usual history proforma to match the screening questions.

Results Of the 100 patients 25 (25%) would never be able to donate blood (18 sexually active men who have sex with men (including 4 with HIV), 6 with precluding health conditions, 1 ex-intravenous drug user). There were 13 (13%) not eligible to donate blood for up to 12 months (9 'high risk' sexual contact in last 12 months, 2 travel related, 1 pregnant, 1 on PEP post needlestick). Of these and the remaining eligible patients (62%), only 18 (24%) have donated (or attempted donation) previously.

Discussion We may not think of a GU clinic as a location to identify blood donors, however we found that 75% of the patients seen were potentially eligible. No additional time was needed to identify potential donors and only a brief intervention or posters in the clinic could be used to promote or signpost blood donation.

P182 CHLAMYDIA POSITIVE TESTING TO TREATMENT TURNAROUND TIME (TAT) APRIL TO DECEMBER 2016

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10.1136/sextrans-2017-053232.225

Introduction Reduction in time to treatment for those with STIs is key for reducing negative sequelae, identifying and treating STIs in partners and preventing onward transmission. BASHH 2014 Standards stipulate that results should be available within 10 working days of testing but there are no standards published for time from test to treatment. In our service patients are told to access results after 7 days. Our results management team contact untreated patients 7 days after testing.

Aims To ascertain the time period between STI test date, availability of result and receipt of treatment for those testing positive for chlamydia within a large multi-site service.

Methods A retrospective audit of the sexual health service electronic patient record (EPR) was undertaken from April to December 2016 identifying all chlamydia positive results across our service. Date of test, availability of result and treatment received was analysed. The following data was analysed.

Results 2897 patient records were identified for analysis. 550 were excluded due to incomplete data. 2347 records were analysed. 63.9% of results were available in 72 hours (mean 48 hours) and 96.2% in 7 days. 51.7% were treated within 48 hours of result availability, 56% within 7 days, 92.2% within 14 days and 97.5% by 28 days.

Discussion The majority of results are available within 72 hours however <60% of patients were treated within 5 days. Patients will now be advised to access the results within 3 days and the service will contact untreated patients within 5 days of a positive result.

P183 RETROSPECTIVE ANALYSIS OF THE UTILISATION OF SCROTAL ULTRASOUND SCAN IN SEXUAL HEALTH CLINIC

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Introduction Most scrotal/testicular symptoms and signs are benign. US Scan is investigation of choice in these patients. However, several studies have shown ultrasound scan findings rarely changes management of these patients. Our aim was to understand how ultrasound scan influenced the diagnosis and management of men with scrotal or testicular symptoms seen in our sexual health clinic.

Methods Retrospective data collected from clinical records of all men seen in sexual health clinic and referred for US scan between 2010 and 2016. Data collected include age, presenting symptoms, STI screen, clinical and ultrasound finding.

166 men had ultrasound scan. 23 men excluded due to incomplete data. Data collected and analysed for 143 men.

Results Median age was 33 years (range 15 – 72 years). Common scrotal/testicular symptoms were: lump 72 (50%), aches/pain 45 (31.5%), others 15 (10.5%). Ultrasound scan diagnoses were: Benign epididymal or tunica albuginea cyst 40 (28%), Varicocele 25 (17.5%), Hydrocele 15 (10.5%), Normal 34 (24%), other 26 (18%), Cancers (testicular 2 and sarcoma 1) (2%). 7 men were referred to urologist for cancer treatment and embolization of varicocele.

Discussion Most men had benign scrotal conditions or normal findings confirmed on scan. This did not change their management plan. Two cases of testicular cancers were initially suspected on clinical examination.

P184 ADHERENCE TO PCP PROPHYLAXIS GUIDELINES IN HIV POSITIVE PATIENTS

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Introduction Pneumocystis Pneumonia (PCP) prophylaxis is often continued despite acceptable CD4 counts in HIV positive individuals on antiretroviral (ARV) treatment. Both BHIVA and EACS guidelines advise discontinuing prophylaxis if the CD4 count is >200 cells/mm3 for 3 months, EACS additionally states that prophylaxis should be stopped if the patient has a CD4 count of 100-200 and an undetectable Viral Load (VL) for 3 months.

Methods We analysed the case notes of all individuals actively receiving Co-trimoxazole prophylaxis prescriptions, and assessed clinical details, CD4 count and VL data to decide whether their continued prescription was in accordance with current guidelines.

Results We identified 32 patients, 27 male, currently on Co-trimoxazole prophylaxis. 18 individuals (56%) met the criteria for continuing PCP prophylaxis. Of the remaining 14, 3 individuals were on immunosuppressive medications for co-morbidities, and were therefore appropriately receiving prophylaxis. 11 of 32 individuals (34%) were found to be receiving Co-trimoxazole despite meeting guidance for discontinuing prophylaxis. 8 of these patients met the BHIVA guidelines, while an additional 3 met the EACS guidelines.