groups considered to be highly vulnerable to infection, including MSM. This present study was conducted to answer key questions with a view to gaining a better understanding of the reality of MSM with regard to HIV/AIDS at AAS. The results are to contribute to the development of an appropriate response strategy.

Methodology The study's aim was to identify possible paths of action and strategies pertaining to MSMs' access to STI/AIDS care, treatment and prevention services at AAS. The study was based on a questionnaire focusing on MSMs' contextual environment and the socio-behavioural factors that determine their vulnerability to STIs and HIV.

Principle Results The questionnaire was administered among 84 MSM at the Centre Oasis, at places where they gather or at their homes. Of those men, 13% are between 17 and 19 years old; 33% between 20 and 24; 25% between 25 and 29; and 29% age 30 and over. 78% are single; 5.2% have a girlfriend; and 16.8% are married to a woman. Survey participants' first sexual experience was with an MSM friend in 70.5% of cases; with an unknown partner in 18.3% of cases; and with classmates in 11.2% of cases. 89.4% of the MSM surveyed consented to their first sexual encounter with another man; their motivation was—sexual desire (68%); curiosity (12%); need of money (11%); need of a service (9%). 47% used a condom during that first sexual encounter, from which 13% emerged with injuries and bleeding. 81% of those surveyed maintain parallel sexual relationships with women. 83% are aware of HIV; 69% gonorrhoea; 61% syphilis; and they do not master the other STIs. 97% know that unprotected sex is high-risk; 83.4% know about relevant risks from contaminated objects, and 58.1% are familiar with relevant risks from blood transfusions. 61.1% systematically use condoms during sex with other men.

Conclusion This exploratory study has allowed us to gain a number of insights. We will now use this data as a basis for improving the services we offer to MSM.

Abstract P1-S2.38 Table 1 Incidence rates of urethral discharge among MSM coming into the Avahan clinics

Characteristics	IR per 100 PY Incidence rate per 100 person years	95% Confidence limits Lower	Upper	HR	p Value
Typology (Self-identity)					
Kothi (Receptive)	6.4	6.1	6.6	Reference	
Double Decker (Versatile)	7.3	6.9	7.6		
Panthi (Penetrative)	14.5	14	15.2	1.04	<0.001
Number of years in commercial sex					
<5 years	5	4.5	5.6	Reference	
2–5 years	4.6	4.1	5.2		
>1 year	14.9	14.5	15.3	4.29	<0.001
Number of clients per week					
<5 clients per week	2.8	2.5	3.2	Reference	
6–10 clients per week	3.6	3.1	4		
>10 clients per week	6.7	5.9	7.6	1.62	<0.001
Self-reported condom use					
Condom used in last sex	4.3	4.1	4.4	Reference	
No condom used in last sex	15	14.5	15.4	2.28	<0.001
Cefixime and azithromycin (Presumptive treatment—PT given in the first three clinic visits)					
Given PT	7.9	1.7	1.9	Reference	
Not given PT	11.1	20.8	21.9	2.79	<0.001
Number of visits per year to the clinic					
More than 8 visits per year	0.5	0.4	0.6	Reference	
7–8 visits per year	0.8	0.6	0.9		
5–6 visits per year	0.9	0.7	1		
3–4 visits per year	1.3	1.28	1.5		
1–2 visits per year	27.6	27	28.3	0.85	<0.001

P1-S2.39 CHARACTERISTICS OF LYMPHOGRANULOMA VENEREUM (LGV) INFECTION AMONG HOMOSEXUAL MEN IN MELBOURNE.

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Background Lymphogranuloma venereum (LGV) has re-emerged among men who have sex with men (MSM) internationally. Previous cases among MSM in Australia have been reported. We aimed to characterise a series of LGV cases seen at the Melbourne Sexual Health Centre.

Methods We reviewed all cases of LGV seen at the Melbourne Sexual Health Centre between 2005 and 2010. During this period MSM who were diagnosed with rectal chlamydia using strand displacement assay were routinely questioned about symptoms of proctitis using a symptom check list. Those with symptoms of proctitis had specimens forwarded for *Chlamydia trachomatis* omp1 genotyping. Genotyping of chlamydia-positive first void urine and penile ulcers in MSM was undertaken on selected MSM based on clinical presentation.

Results During the study period, of 292 chlamydia positive ano-rectal specimens that were genotyped, 21 (7.2%) tested positive for LGV. Of the eight chlamydia positive urine or penile specimens genotyped, four were positive for LGV. There was also one case of an inguinal bubo that tested LGV positive from aspirated pus. In all cases L2 or L2b type was isolated. Of the 25 cases of LGV, 18 (72%) were in HIV positive men. Of the 21 men who had ano-rectal LGV, all had ano-rectal symptoms, namely—ano-rectal pain (71%), anal discharge (62%) and/or rectal bleeding (52%). All but one of the LGV infected men received at least a 3-week course of doxycycline 100 mg twice daily. Two men with ano-rectal LGV remained LGV positive on follow-up when tested 3 months later. Both these patients were noted to have had unprotected sex following initial treatment, hence, it is unclear whether this was due to treatment failure or reinfection.

Conclusions LGV continues to be seen among MSM in Melbourne presenting with proctitis. Genotyping of anal chlamydia infections has been useful in distinguishing LGV from the more common non-LGV chlamydial infections, therefore ensuring appropriate antibiotic therapy and follow-up are instigated.

P1-S2.40 HIV AND SYPHILIS COINFECTION AMONG MEN WHO HAVE SEX WITH MEN, 34 STATES, USA–2009

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Background During the early 2000s, reports of the re-emergence of syphilis among men who have with men (MSM) in the USA described a high prevalence of HIV coinfection in different localities, often among middle-aged men. Since 2001, syphilis has increased among men in younger age groups. Here, we present a description of HIV coinfection among MSM of different races and ethnicities with primary and secondary syphilis across multiple states during 2009.

Methods We reviewed data reported to CDC from states in the USA that reported HIV coinfection status for at least 70% of cases of primary and secondary (P&S) syphilis during 2009. These data originated from P&S syphilis patient interviews and included census region, sex, sex of sex partner, race, ethnicity, and HIV infection status. Prevalence of coinfection was calculated using coinfected patients as the numerator, and all P&S syphilis patients who were asked about their HIV status as the denominator.

Results 34 states and Washington, DC from all regions of the USA met inclusion criteria, accounting for 82% of all P&S syphilis in the