

and serosorting, we examined how often men have UAI and report serosorting with three casual partner types that differ in the degree of familiarity.

Methods We included 240 HIV-negative men of the Amsterdam Cohort Study among MSM. We distinguished three casual partner types—one-night stand (“met by chance and had sex only once”); multiple-time casual partner (“met by chance and had sex several times”); and sex buddy (“contacted on a regular basis for sex but not considered a steady partner”). Serosorting was defined as UAI with an HIV-negative partner. GEE analyses were performed to examine the association between casual partner type and sexual risk behaviour.

Results 240 participants accounted for 362 reports of anal intercourse, of which 206 (57%) with one-night stands, 95 (26%) with multiple-time casual partners, and 61 (17%) with sex buddies. The proportion of UAI was 19% (39/206) with one-night stands, 20% (19/95) with multiple-time casual partners, and 34% (21/61) with sex buddies. When performing UAI, 21% (8/39) reported serosorting with one-night stands, 42% (8/19) with multiple-time casual partners, and 52% (11/21) with sex buddies. Analyses revealed that only men with a sex buddy were significantly more likely to have UAI (OR [95% CI] 2.39 [1.39 to 4.09]), but were also more likely to practice serosorting than men with a one-night stand (OR [95% CI] 5.20 [1.20 to 22.52]). No differences were found between the multiple-time casual partner and the other partner types.

Conclusions Men with a sex buddy had more UAI but also reported more serosorting than men with a one-night stand. As a result, the proportion of UAI without serosorting is lower for men with a sex buddy, and therefore men might have less UAI at risk for HIV with this partner type. However, the quality of serosorting with casual partners and hence their protective value against HIV needs to be further established. At this time, we suggest that a distinction between the one-night stand and the sex buddy should be incorporated in future studies as risk behaviour of MSM is significantly different between these partner types.

P1-S2.48 EXPONENTIAL GROWTH OF LYMPHOGRANULOMA VENEREUM DIAGNOSES IN THE UK: INVESTIGATION OF THE LARGEST DOCUMENTED OUTBREAK AMONG MEN WHO HAVE SEX WITH MEN

doi:10.1136/sextrans-2011-050108.105

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Background With over 1500 cases reported, the UK now has the largest documented outbreak of Lymphogranuloma venereum (LGV) among men who have sex with men (MSM). Of particular concern is the recent exponential rise in cases—a third of all cases have been reported since 2010. We investigated the characteristics of this outbreak and specifically whether any factors were associated with the sharp upsurge in cases in 2010.

Methods The UK LGV Incident Group launched a diagnostic reference service and enhanced surveillance of LGV in the UK in October 2004. All symptomatic patients attending UK GUM clinics who were chlamydia-positive or contacts of positive cases were referred to STBRL in London and later also to the Scottish Bacterial Sexually Transmitted Infections Reference Laboratory in Edinburgh for confirmation. Enhanced LGV surveillance forms were completed by clinicians caring for cases and submitted to the HPA for analysis. An epidemic curve was plotted and the point of exponential growth estimated. The characteristics of cases prior to and during the exponential growth phase were compared.

Results Since 2003, 1570 LGV cases have been reported in the UK, of which 1268 (81%) had enhanced surveillance forms available. All

but 8 (99%) were in MSM and most (77%) were seen in London, Brighton and Manchester. The point of exponential growth was estimated as 1st October 2009. Compared to cases prior to this date, cases in the growth phase were more likely to be older (41% vs 38% aged over 40), to be HIV positive (84% vs 78%), to be HCV antibody positive (27% vs 22%), to report unprotected anal intercourse (UAI) (80% vs 77%) and fisting (19% vs 14%), to present outside London (32% vs 27%), and to have acquired LGV in the UK (91% vs 87%). Overall, median case age was 38, 84% were white and 11% reported they acquired the infection outside the UK, mostly in Western European countries associated with the epidemic. UAI was reported by 78% of cases and at least 50 were identified as re-infections.

Conclusions LGV is becoming endemic in the UK and is characterised by HIV positive MSM involved in dense sexual networks. Although cases associated with the recent upsurge are more geographically widespread, there is no evidence of dispersal among lower risk or HIV negative MSM. LGV control will require intensified awareness raising and outreach among at risk populations. Regression modelling of key variables is underway to investigate and validate these findings.

P1-S2.49 CHLAMYDIA AND GONORRHOEA TRANSMISSION AMONG MEN WHO HAVE SEX WITH MEN IN AMSTERDAM, IS INDEPENDENT OF NETWORK FACTORS OR PARTNERSHIP CHARACTERISTICS

doi:10.1136/sextrans-2011-050108.106

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Background Partnerships are essential for transmission of sexually transmitted infections (STI). Among MSM, variation in partnerships is common. We have analysed risk factors for STI by studying partnerships.

Methods The study population was recruited from the STI outpatient clinic of the public health service of Amsterdam, the Netherlands. Inclusion criteria were male gender, having had sexual contact with men in the past 6 months, age ≥ 18 years, and understanding of written Dutch or English. Recruitment occurred from July 2008 to August 2009. Participants were screened for chlamydia (CT), gonorrhoea (NG), syphilis, and HIV (opting-out strategy). Participants completed a questionnaire including demographics and detailed questions about sexual behaviour in self-defined relationships with a steady partner and the last three other partners within the previous 6 months. Logistic regression analysis was used to identify risk factors for CT and NG.

Results 2731 MSM reporting 7397 partnerships were included; median age was 39 years (IQR 31–45). CT prevalence was 12.5% (n=342), NG prevalence was 11.1% (n=303), and CT/NG coinfection was found in 2.6% (n=71) of the MSM. Meeting partners online was common (53% met at least one of the partners online), but not associated with STI (CT—OR 1.2 95% CI 0.95 to 1.5 and NG—OR 1.2 95% CI 0.9 to 1.5), just as having concurrent partnerships (CT—OR 3.2 95% CI 0.4 to 23.6 and NG—OR 1.3 95% CI 0.3 to 5.6). In multivariable analysis, independent predictors of CT were having ≥ 5 known partners in the last 6 months (OR 1.7 95% CI 1.2 to 2.3), receptive unprotected anal intercourse (OR 2.1 95% CI 1.5 to 2.8), NG coinfection (OR 2.0 95% CI 1.5 to 2.8), and HIV coinfection (OR 1.8 95% CI 1.4 to 2.4). Independent predictors of NG were group sex (OR 1.5 95% CI 1.1 to 2.1), being in a different 10-year age category than the partner (OR 1.4 95% CI 1.04 to 1.8), CT coinfection (OR 2.1 95% CI 1.5 to 2.8), and HIV coinfection (2.2 95% CI 1.6 to 2.9). Age ≥ 45 years (OR 0.4 95% CI 0.2 to 0.6) and being bear type (OR 0.4 95% CI 0.2 to 0.9) were associated with lower NG risk.

Conclusions CT and NG infections are associated with positive HIV status and other STI coinfections. We confirmed the association between NG and CT and several known risk factors of the index patient; surprisingly, none of the partnership factors (eg, concurrency, meeting place, or partner's HIV status), except age difference, were associated with NG or CT.

P1-S2.50 ANAL NON-L CHLAMYDIA TRACHOMATIS INFECTION IN MEN WHO HAVE SEX WITH MEN, AT L'ACTUEL, MONTREAL, QUEBEC

doi:10.1136/sextrans-2011-050108.107

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Few cases of sexually transmitted Hepatitis C infection (HCV) in men who have sex with men (MSM) had been reported in the literature.

Background The incidence of genital infection from non-L *Chlamydia trachomatis* (CT) is increasing in the province of Quebec. Traditionally it was more prevalent in young women. In the last few years, CT infection has emerged in men who have sex with men (MSM) group. The objective of this study was to describe anal non-L CT infection in MSM in an HIV-STI clinic in a large urban setting.

Methods Retrospective study of anal non-L CT cases diagnosed at Clinique l'Actuel in 2010. We collected information on age at diagnosis, HIV status, CT serovars, symptoms, mode of transmission and concomitant presence of CT in urine. An anal swab specimen was collected with a TAAN test (BD Probe Tec TM).

Results From 2006 to 2009, we diagnosed respectively 42, 58, 82 and 118 anal non-L CT infection in MSM. In 2010, we diagnosed 154 different anal non-L CT infections in 152 MSM. Patient's age at diagnosis was 33 years (IQR=25–38) from 18 to 70 years. 28% were HIV+ at time of diagnosis. Anal infection was primarily caused by serovars J (35%), G (31%), D (23%), E (10%), F (1%) and C (1%). Among HIV patients the serovars was predominantly J (46%), D (30%) and G (24%). But this difference was not statistically significant. Anal non-L CT infection was detected in asymptomatic patients while screening in 54% of case. 7% of MSM had no symptom but consulted because they were notified by a sexual partner. 39% had symptoms—proctitis (26%), urethritis (11%) or symptom of other STI including syphilis and HIV primary infection (2%). Mode of transmission for the anal infection was not specifically specified in the file of the patients, but 88% reported anal unprotected penetration in the past year, 12 % did not report anal penetration but had mouth to anus contact (rimming) or friction from penis to anus. One patient reports sharing anal toys. Urine CT was positive in 18% of MSM, so those MSM had two infected sites.

Conclusion Given the high rate of positive results, MSM should be screened with a TAAN test for anal CT infection. This screening should be included in the regular follow-up of HIV patients. MSM community should be aware of this emerging infection. Public health authority should focus on developing and promoting new guidelines of screening, access to validated test with identification of serovars.

P1-S2.51 SEXUALLY TRANSMITTED HCV IN MSM IN MONTREAL

doi:10.1136/sextrans-2011-050108.108

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Methods A retrospective analysis of the clients who attend the "Gay Screening Clinic" (GSC) at Clinique medical l'Actuel (Montreal, Canada) between May 2009 and April 2010 was conducted.

Results Among the 1010 patients included in the analyses we found five cases of new HCV infection which seems to be acquired by sexual transmission. All of them were male and MSM, none of the cases had previous history of IDU, but three reported having had sexual relation with IDU partners. All of them were previously vaccinated for Hepatitis A and B and screened for HIV. None of them were coinfecting with HIV, but one was coinfecting with Syphilis and one with Gonorrhoea. Patients infected with HCV were older than non HCV patients (37 years vs 32 years) and had a higher number of sexual partners during the last 12 months (16 part. vs 9 for the non HCV patients). One of the HCV cases reported not having anal intercourse, two reported having had occasional unprotected anal intercourse and two reported always using condom for anal intercourse.

Conclusions As in other urban centers, cases of sexually transmitted HCV had also been found in Montreal. This prevalence of 0.5% is very low compared to our HIV population in which the prevalence of sexually transmitted HCV is 3%. The particularity of MSM with recently acquired HCV by sexual transmission seems to be related to their engagement in sexual relation with high number of concurrent partners.

P1-S2.52 RISK FACTORS FOR STIS AMONG MSM ATTENDING A SEXUALLY TRANSMITTED DISEASE CLINIC IN MONTREAL, CANADA

doi:10.1136/sextrans-2011-050108.109

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Background Often STIs are not diagnosed and not treated because people don't have access to appropriate healthcare screening facilities and to care. At Clinique l'Actuel (Montreal, Canada) we developed Gay Screen Clinic (GSC) as a new concept giving rapid access to men who have sex with men (MSM) to an appointment for STI screening. We then assessed the extend and risk factors of STIs in a population of men having sex with men (MSM) attending the GSC.

Methods We did a retrospective analysis of the last 1000 attendees to the GSC at Clinique l'Actuel in 2009–2010. Multivariable analyses were conducted to identify the factors associated with history of STIs.

Results Participants were all MSM with a mean age of 32 years (ranged from 18 to 70 y). In total, 50% (n=506) of them self reported history of STIs and 236(24%) of them had a positive sexual health screen at this visit. STI diagnoses included genital herpes (n=105, 14 %), condylomes (n=79, 8%), syphilis (n=43, 5%), chlamydia infection (n=32, 3%), HIV (n=10, 1%), Gonorrhoea (n=9, 1%) and HCV (n=5, 1%). 32% of the attendees had sexual relations in bath houses and 43% with anonymous contacts. In multivariate analyses, past history of STI was significantly associated with higher age (OR=1.02, p=0.001), higher number of sexual partners in the last 12 months (OR=1.02, p=0.015), having sexual contact in bath houses (OR=1.46, p=0.021) and with unknown partners met through internet or in backrooms (OR=1.53, p=0.004), using recreational drugs (OR=2.01, p=0.001) and having only male partners (OR=1.60, p=0.023) rather than male and female sexual partners.

Conclusions STIs were common among non HIV MSM attending the GSC in Montreal. Even after many years of prevention campaign MSM still have high risk sexual behaviour. Physician should routinely enquire about drug use of their patients in order to prevent new STIs. Targeting specific sexual networks is needed to be more effective.