exploring design possibilities and technology features will be followed by the formative evaluation of interface design through qualitative and controlled usability studies with target users.

**Results**

In this paper we report on a user-centred approach that allows for the successful capture and integration of social science methods to encapsulate user requirements with usability principles in order to develop an effective and user acceptable self-managing STI system.

**Discussion and/or Conclusions**

Working in a cross-discipline collaboration the overall aim is to investigate the impact of user-centred methods in the design of innovative mobile phone and web technology based rapid testing.

**P23**

**THIS IS A POLICY NOT A PILOT: HOW TO IMPLEMENT ROUTINE OPT-OUT HIV TESTING FOR ACUTE MEDICAL ADMISSIONS IN AN NHS TRUST IN A HIGH PREVALENCE AREA**

doi:10.1136/sextrans-2012-050601c.23

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**Background and Aims**

Feasibility and acceptability of HIV testing in acute medical settings has been demonstrated in pilot studies. Whereas we report our success of embedding HIV testing in routine clinical care, delivered and sustained by medical staff in an NHS trust.

**Methods**

From July 2011 all patients aged 16–79 years, attending the Acute Medical Unit (AMU), have had a standard HIV test unless they decline. Laboratory costs are funded by the local NHS. Literature was produced for staff and patients. Verbal consent and test ordering is carried out by general medical doctors and AMU nurses, all having trained by the local HIV team. AMU proformas were updated with sections for HIV test offer and reason for refusal. The HIV team made regular AMU visits to motivate, troubleshoot and feedback progress. From the outset, nurses were more proactive than doctors in applying the policy. Building on their enthusiasm, nurses were empowered so that by October 2011 AMU visits were weaned as nurses took the lead to enforce the policy.

**Results**

3709 attendees in the first 6 months, median age 57 years, 30% female, 54.7% Caucasian, 6% Black African. 1390 (37.5%) had signiﬁcant side effects or intolerance to other drug classes. Other factors included cardiovascular risk (20%), co-infections (18%) and co-morbidities (18%). 14 patients were reviewed for immunological response following treatment. Two were excluded (one unrelated death). Of the remaining 15 patients, 46% had a suppressed viral load prior to starting RAL, and 92% were suppressed after 12 months of treatment.

**Conclusions**

This study demonstrates that identifying common indications for switching to RAL and MVC within a regional network supported the process of formulating criteria to prescribe these newer drugs. This unified approach within the region led to improved and timely access to these drugs thereby improving outcomes for patients at small centres. The agreed prescribing criteria were in instances where combination therapy was not possible due to intolerability, side effects, allergies, resistance, drug interactions, co-morbidities, or HIV-2 (for RAL).

**P25**

**EPIDEMIOLOGICAL TREATMENT FOR CHLAMYDIA CO-INFECTION IN MSM WITH A PRESUMPTIVE DIAGNOSIS OF URETHRAL GONORRHOEA IN S. AUSTRALIA**

doi:10.1136/sextrans-2012-050601c.25

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**Background**

Rates of up to 30% *Neisseria gonorrhoeae* (NG) and *Chlamydia trachomatis* (CT) co-infection occur in men. Historically, Men who have Sex with Men (MSM) were considered to have a low incidence of CT. However, increasing prevalence of CT and NG in MSM, especially asymptomatic anorectal infection is a reality. Despite well-established guidelines providing presumptive co-treatment for CT to patients with treatment indications for NG, various centers in Australia differ in their approach to management in MSM. At our Clinic, epidemiological treatment for CT had only been given to heterosexual males with a presumptive diagnosis of urethral gonorrhoea.

**Aim**

This study was to determine if the local prevalence of CT co-infection in MSM justifies epidemiological treatment when a presumptive diagnosis of urethral gonorrhoea is made.

**Methods**

A retrospective review of case notes data, analysed for NG and CT co-infection in male patients was made over a 10-year period from 2001 to 2010. Data analysis was performed using STATA (V.10).

**Results**

The proportion of heterosexual males who were NG smear positive and also found to be CT positive was 38/274 (13%) CI 8.4% to 18.7%. The proportion of MSM who were NG smear positive and found to be CT positive as well was 22/207 (10.7%) CI 9% to 15%. No patients had NG positive and CT negative.

**Conclusion**

Based on this study, the guidelines at our Clinic were changed. All MSM with a presumptive diagnosis of NG infection are now given epidemiological treatment for CT infection as heterosexual men.
P25 Epidemiological treatment for chlamydia co-infection in MSM With a presumptive diagnosis of urethral gonorrhoea in S. Australia

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