microscopy, nucleic acid amplification tests (NAAT) and culture. The NAAT test used was Gen-Probe APTIMA Combo 2, confirmed by the Aptima GC mono-assay.

Results 152 cases were identified; 63% of cases were in men, 75% were heterosexual. The median age was 25 years (IQR 20–33.5). 24% had previously had gonorrhoea, 29% had concurrent sexually transmitted infections and 5% had HIV co-infection. 88% of patients received correct treatment as per British Association for Sexual Health and HIV guidelines. 76% were offered TOC; of these, 43% attended for TOC. TOC was negative in all patients tested (NAAT and/or culture). 4% of patients attending TOC were retreated because of re-infection risk. 22% (82/369) of partners were tested and treated for gonorrhoea; however, written or official verification of this was limited.

Discussion Our data show that a high proportion, though not all, of patients are offered correct treatment at our centre, but only 43% return for TOC. Of those who return, persistent infection, to date, has not been detected at our centre. This may indicate that guidelines can be refined to direct TOC towards populations at greater risk of persistent or resistant gonorrhoea infection. More data regarding the best time to offer TOC is also required, as earlier TOC may improve uptake.

04 PHARYNGEAL GONORRHOEA: ASSESSING TREATMENT RESPONSES IN AN ERA OF UNCERTAINTY

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R Artykov,* R K Rabiu, J A White. *Guy's and St Thomas' NHS Trust, London, UK*

Background The last decade has seen a paradigm shift in diagnosis and treatment of gonorrhoea (GC). Recent guidelines are hampered by lack of evidence for optimal timing for test of cure (TOC) and method of testing. The majority of pharyngeal GC (pGC) is seen in MSM and is culture-negative. Traditionally infection is harder to eradicate at this site and TOC is now routinely recommended.

Aim To assess treatment responses and TOC strategy for pGC over a 2-year period that included multiple changes in practice.

Methods Retrospective case note review of all pGC diagnosed by Aptima Combo 2 (AC2) and confirmed with Aptima GC from January 2010 to January 2012 at two urban UK GUM clinics. Treatment regimens changed from oral to parenteral and TOCs performed at 2 or 3 weeks across the study period.

Results A total of 523 cases of pGC were diagnosed; 514 (98.3%) were in men. Of the 343 where culture was taken concurrently, 63 (18.4%) were culture positive. Ciprofloxacin resistance was present in 33% of pGC isolates but none showed cefixime resistance. Of the 476 where pGC treatment was given and documented by us, most were treated with either cefixime 400 mg PO (51.3%) or ceftriaxone 500 mg IMI (40.1%), usually with azithromycin 1 g PO or doxycycline 100 mg bd ¡Ý7 days PO. Of the 386 that underwent TOC within 90 days of treatment, most had both culture and AC2 taken. Positive TOC was seen in 14 (3.6%) patients (only five were culture-positive); all had received cefixime-based regimens as their first line GC treatment. High rates of ongoing sexual risk clouded the determination of treatment failure. The majority of TOCs done at 2 weeks (31/32; 97%) or 3 weeks (43/44; 98%) were AC2-negative. Two AC2-positive TOCs at 7 and 8 days post-treatment, respectively, were difficult to interpret (see abstract O4 table 1).

Conclusions Our data support the new guidelines for pGC treatment with ceftriaxone 500 mg regimens followed by TOC at 2 weeks with a molecular test. Prospective studies and ongoing surveillance are needed to monitor the efficacy of this strategy.

Abstract O4 Table 1

Antibiotic regimen used for pharyngeal GC treatment	No. of patients with TOC	No. with negative TOC result (%)
Cefixime 400 mg + AZI 1 g	161	153 (95%)
Cefixime 400 mg + doxy ≥7 days	10	5 (50%)
Ceftriaxone 500 mg + AZI 1 g	101	101 (100%)
Ceftriaxone 500 mg + doxy ≥7 days	16	16 (100%)
Ceftriaxone 500 mg only	9	9 (100%)
Ceftriaxone 250 mg + AZI 1 g	3	3 (100%)
Ceftriaxone 250 mg + doxy ≥7 days	2	2 (100%)
Ceftriaxone 250 mg only	5	5 (100%)
Azithromycin 2 g only	9	9 (100%)
Ciprofloxacin 500 mg + AZI 1 g	6	6 (100%)

AZI, azithromycin; doxy, doxycycline 100 mg bd; TOC, test of cure.

05 PARTNER NOTIFICATION FOR GONORRHOEA: ANALYSIS OF OUTCOMES USING SURVEILLANCE DATA

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E Savage,* K Marsh, C M Lowndes, S Duffell, A Zaman, G Hughes. *Health Protection Agency*

Background Partner notification (PN) is an essential component of STI control but can be difficult where index cases have multiple casual partners. Guidelines recommend that for gonorrhoea, a minimum of 0.4 contacts/case in large conurbations, and 0.6 contacts/case elsewhere, should be screened. We investigated the effectiveness of newly introduced surveillance codes for monitoring standards of PN in England.

Objectives To investigate the relationship between PN ratios for gonorrhoea and patient socio-demographic characteristics.

Methods Data on PN from the Genitourinary Medicine Clinic Activity Dataset (GUMCAD) were analysed.

Results Reporting on PN began on a rolling basis in 207 GUM clinics during 2011. Provisional data on PN were available from 171 clinics reporting data covering 951 clinic months in total, during which there were 7423 cases and 2749 contacts. In this period, the overall PN ratio for gonorrhoea was 0.37 contacts/case. PN ratios were highest for clinics in non-urban areas (0.42 vs 0.36 in urban areas) but there was no difference between PN ratios in London and the rest of England. PN was most successful for female partners of heterosexual male index cases (0.44 contacts/case). Of those attending as a contact 26% (707/2749) tested positive for gonorrhoea; 31% of females, 22% of heterosexual males and 24% of MSM.

Conclusions Provisional data suggest that, on average, contact to index case ratios for gonorrhoea are below recommended standards but these are likely to vary considerably by clinic. The high prevalence of gonorrhoea among contacts emphasises the importance of PN for case finding and reducing transmission. Further analysis to better understand the strengths and limitations of these data is warranted.

06 SENIORITY IMPROVES SPECIFICITY: DIFFERENCES IN PID DIAGNOSIS BETWEEN DIFFERENT GRADES OF CLINICIAN

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[1]G C Morris,* [2]C M W Stewart, [2]J D Wilson. *[1]Department of Genitourinary Medicine, Leeds Teaching Hospitals, Leeds, UK; [2]Leeds Teaching Hospitals, Leeds, UK*

Background Pelvic inflammatory disease is difficult to diagnose; dependent on interpretation of clinical symptoms and signs that lack sensitivity and specificity. Differences in the rates of PID diagnoses have been noted among senior sexual health physicians. Given the potential severe consequences of untreated PID, we