

infection. Effective partner notification (PN) is key to identifying sexual contacts that may have been exposed, providing the opportunity to offer necessary advice, support and testing.

**Aim** This audit explored current PN practices across the North East in order to identify opportunities for improvement and inform future guidance.

**Methods** All genitourinary medicine and infectious diseases clinics across the North East were asked to complete questionnaires for up to ten newly diagnosed cases of HIV between January and December 2010, and provide additional background information on PN arrangements. Data were analysed using EpiData version 3.1.

**Results** Seven out of nine (78%) clinics responded. PN was discussed with 82% (46/56) of newly diagnosed patients and documented in the records of 77% (43/56). The time taken to complete all PN outcomes ranged from 0–29 weeks (median 1.5 weeks) and a mixture of methods were used to calculate the PN period. A total of 70 regular partners were recorded, 32 of which were tested and 44% (14/32) found to be HIV positive. 95 casual partners were recorded, nine of which were tested and none found to be HIV positive. Additional outcomes such as safe sex discussions and condom use were generally less frequently documented.

**Discussion and Conclusion** Although this sample is relatively small, there was engagement from the majority of regional services, suggesting that it is likely to be representative of local practice. It is clear that there is variation in current PN practices between clinics, and there are a number of challenges which may be particularly pertinent to HIV infection. These findings will be used to inform local policy and standards with the aim of improving the quality of local services and ensuring accountability for actions.

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# AN ANALYSIS OF PATIENT CHARACTERISTICS ASSOCIATED WITH GONOCOCCAL RESISTANCE TO PAST THERAPEUTIC AGENTS IN ENGLAND AND WALES

doi:10.1136/sextrans-2012-050601c.30

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**Background** Antimicrobial resistance in *Neisseria gonorrhoeae* restricts effective treatment options. Recent UK treatment guidelines recommend ceftriaxone as first line treatment. If ceftriaxone becomes unsuitable for treating gonorrhoea there are no suitable available alternatives. The potential for using past therapeutic agents for gonorrhoea treatment should be assessed.

**Aim(s)/Objective(s)** Identify risk factors associated with antimicrobial resistance to penicillin, tetracycline and ciprofloxacin.

**Methods** Data from the Gonococcal Resistance to Antimicrobials Surveillance Programme were analysed for trends in antimicrobial resistance across sub-groups of the Gonococcal Resistance to Antimicrobials Surveillance Programme population. Using 2010 data patient variables associated with penicillin, tetracycline and ciprofloxacin resistance were identified using univariate and multivariable analyses of ORS.

**Results** Rates of penicillin, tetracycline and ciprofloxacin resistance have increased across all regions in England and Wales in recent years, with very high levels found in white MSM. Lower rates of resistance, with <15% prevalence, indicating a susceptible population, are found in women (penicillin 6.4%, ciprofloxacin 12.8%), black ethnicity (penicillin 6.1%, ciprofloxacin 13.4%), and in some cases heterosexual men (penicillin 13.2%) and those aged under 24 (penicillin 12.6%). Univariate and multivariable analysis identified patient variables, including sexual orientation, ethnicity and age as strongly associated with penicillin, tetracycline and ciprofloxacin resistance.

**Conclusions** By using sub-group population prevalence data on resistance, as well as information about patient variables strongly associated with resistance, it may be possible in some cases to adapt treatment regimens to make use of previously recommended antimicrobials and preserve the use of ceftriaxone for high-risk groups.

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# HOW IMPORTANT IS IT TO KNOW WHERE INDEX PATIENTS MEET THEIR SEXUAL PARTNERS IN ORDER TO CONTROL THE TRANSMISSION OF SEXUALLY TRANSMITTED INFECTIONS?

doi:10.1136/sextrans-2012-050601c.31

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**Background** Learning where people have met their sexual partners has previously been acknowledged as a way of identifying key locations that are functional to sexually transmitted infection transmission.

**Aims** To gather local data on where patients diagnosed with chlamydia, gonorrhoea, syphilis, HIV, trichomonas and hepatitis B have met their partners. This is the first stage of an on-going project which aims to develop a more targeted health promotion intervention(s) for key locations in Bristol identified as being important for STI transmission. The ultimate aim is that this intervention(s) will contribute to a reduction in STI transmission rates and therefore STI prevalence(s) in Bristol.

**Method** Patients were asked where they met their sexual partners during all health adviser partner notification interviews conducted in 2011. 2052 interviews were conducted and data were collected from 1257 patients.

**Results** Across all patients, the most regularly cited meeting place was in a bar or club (29%) This was followed by “through friends/old friends” (28%). 12% met their sexual contacts via the internet. The most common mode of meeting contacts in heterosexual patients was via friends (31%) while for gay men it was via the internet (36%).

**Discussion** The data provides the names of key locations in Bristol and a number of internet sites that are important for transmission. These locations can now be targeted by health promotion and outreach work in order to contribute to a reduction in STI transmission and prevalence. Over a quarter of all sexual contacts were met via friends or they were a friend of the patient. It is likely that the perception of STI risk diminishes if a contact is known or if they share the same social network. As well as targeting locations and internet sites, further research is now needed to explore patient’s perception of STI risk, alongside health promotion work that highlights potential misperceptions.

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# PARTNER NOTIFICATION (PN) WITHIN NON-SPECIALIST SERVICES

doi:10.1136/sextrans-2012-050601c.32

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**Background** The local board has the highest rates of diagnosis of genital Chlamydia in Scotland. PN is critical to breaking the chain of infection but there is a clear lack of consistency in its provision outside the specialist services.

**Aim** To meet the NHS Health Improvement Scotland Standard 4.2 for Sexual health services; “Individuals are offered partner notification in all settings delivering sexual healthcare, including in primary care, youth services and community pharmacies”.

Abstract P32 Table 1 Partner notification of chlamydia positive patients in 2011

	March	April	May	June	July	August	September	October	November	December
Chlamydia positives	38	39	49	67	40	68	63	43	36	39
% of positives with consent for PN	8	10	16	34	40	32	38	47	56	62

**Methods** A sexual health adviser was appointed to manage the positive Chlamydia diagnoses made out with the specialist services. This service commenced in March 2011 and coincided with the roll out of Chlamydia and Gonorrhoea PCR testing to these areas. Providers were informed to seek consent for referral at the time of testing and acquire the individual's mobile number. The PN service was advertised through email to all providers who undertake testing and in addition, educational sessions and updates were provided.

**Results** The table shows progressive improvement in the uptake of PN over the course of the year (see abstract P32 table 1).

**Discussion** Despite a marked increase in the referral rate for PN, uptake remains suboptimal. Specific GP practices that rarely test for Chlamydia or refer for PN are identified and contacted, reminding them of the importance of PN.

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### GONORRHOEA IN YOUNG HETEROSEXUALS: OUTBREAK MANAGEMENT AND SAFE SEX MESSAGES

doi:10.1136/sextrans-2012-050601c.33

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**Background** Increases in gonorrhoea infection in young heterosexuals have been reported in two distinct areas of the North East of England over the past 6 months. Multi-agency working between GUM, public health, health protection and communication teams has attempted to increase awareness and reduce transmission. From initial case and partner notification information, there appeared to be misunderstandings about the routes and risks of transmission, along with a perception that a negative chlamydia test could be regarded as an STI "all clear".

**Methods** Following the report of increase in area 1 in September 2011, a number of interventions were put in place, including enhanced surveillance, network mapping of contacts and cases, raising awareness among healthcare professionals, other organisations working with young people and with young people themselves. An increase in cases in area 2 was reported in November 2011. Similar interventions are being introduced and ongoing work to explore any links between the clusters.

**Results** 65 cases of gonorrhoea have been reported in area 1 since May 2011 (compared to a usual annual number of 15); in area 2 clustering of cases has occurred at higher rates than previously seen, although overall number of cases has not increased. Partner notification and network mapping has shown multiple casual partners although no large extended sexual networks. Dual-testing of chlamydia screening samples is now being considered to further outbreak control. We report the lessons learnt from managing these two clusters and how they can be applied to future STI clusters.

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### PARTNER NOTIFICATION FOR HIV: A REGIONAL OUTCOME AUDIT

doi:10.1136/sextrans-2012-050601c.34

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**Background** Partner notification (PN) for HIV facilitates early diagnosis among those at highest risk. Health advisers and HIV nurses from eight clinics (7 GUM, 1 ID) formed a regional HIV network public health group to optimise PN across the region by sharing intelligence of local HIV transmission and monitoring practice against national guidelines and standards. Since there is no national standard for HIV PN outcomes, we undertook a baseline local audit to inform discussion on the possibility of setting a regional standard.

**Objective** To conduct a baseline audit for HIV PN outcomes across the regional HIV network.

**Methods** HIV services across the network undertook a retrospective case note review of all patients newly diagnosed with HIV in 2011. Data were collected on the number of partners verified/reported as tested negative/positive before the index, or within 90, 180 or 360 days, following patient or provider referral.

**Results** Results received from 7/8 clinics are presented below (see abstract P34 table 1).

**Conclusions** Overall PN outcomes are good across the region, although there was wide variation between clinics which makes it difficult to set a single regional standard that is both challenging and achievable for all. Outcomes were verified for most partners, but not possible if tested at an unknown clinic or abroad. The majority of tested partners attended within 3 months, but a small number took up to a year, suggesting PN efforts should continue until the partner is deemed untraceable.

Abstract P34 Table 1 HIV partner notification

	Range per clinic	Overall
Number partners verified tested per case <90 days	0.17–1.3	1.05 (118/112)
Number partners verified or reported tested per case <90 days	0.66–1.33	1.15 (129/112)
Number partners verified tested per case <1 year	0.17–1.38	1.17 (131/112)
Number partners verified or reported tested per case <1 year	0.66–1.53	1.27 (142/112)

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### A COLLABORATIVE APPROACH TO CONTROLLING AN HIV OUTBREAK AMONG INTRAVENOUS DRUG USERS

doi:10.1136/sextrans-2012-050601c.35

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**Background** In 2008 an intravenous drug user (IVDU) admitted to the infectious diseases unit was diagnosed with late-stage HIV. He named five injecting partners, of whom three tested negative for HIV, one refused, and one was untraced. In early 2010 another IVDU was diagnosed, naming two injecting partners of the previous case who had either declined or tested negative in 2008.