P45 THE EFFECT ON *NEISSERIA GONORRHOEAE* SCREENING RATES IN AN INTEGRATED CLINIC FOLLOWING THE INTRODUCTION OF DUAL NUCLEIC ACID AMPLIFICATION TESTS

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Background Nucleic acid amplification tests (NAATs) to detect *Neisseria gonorrhoeae* (GC), allow less invasive sampling and are more sensitive than culture. Aptima combo 2 (AC2) has a high specificity but positive predictive value can be low in low prevalence populations. GC diagnoses may be lower in an integrated family planning (FP) and genitourinary (GU) clinic compared to those primarily providing GU care.
Aim To investigate whether the introduction of GC NAATS into an integrated clinic has increased rates of GC screening and detection.
Methods All patients having a GC screen 4 months prior to and following NAATS introduction were identified by laboratory databases. Notes were reviewed for those diagnosed with GC. Information regarding patient demographics, symptoms and risks were gathered (see abstract P45 table 1).
Results Pre-NAATS: 2307 symptomatic and asymptomatic patients were screened with GC culture of which 20 (0.87%) were positive. Post-NAATS: 3444 symptomatic and asymptomatic patients were screened with AC2 of which 43 (1.25%) were confirmed positive for GC. 217 of the symptomatic patients were also cultured and 18 (8.3%) were positive. Of the 43 positive NAATS tests, 20 patients were also culture positive; 10 were culture negative, 1 grew *Neisseria meningitidis* (isolated in the throat) and 12 had no culture taken. All of the NAATs positive, culture negative individuals had symptoms, signs or high risks for GC. All patients with positive cultures were NAATS positive.
Conclusions Following the introduction of NAATS, the proportion of patients attending clinic who were screened for GC significantly increased and the number of GC diagnoses doubled. This may be due to better acceptability and uptake of screening, including those attending for FP care. NAATs identified more cases of GC than culture alone. There was only one case of a possible false positive. This provides reassuring data to support use of NAATS in this setting.

Abstract P45 Table 1 Patient demographics pre and post NAATs introduction

	Pre-NAATS (n)	Post-NAATS (n)
No. of patients attending (re-attendees not included)	9296	9917
No. of GC screens carried out (% screened of those attending)	2307 (25)	3444 (35)
No. of positive GC tests (%)	20 (0.87)	43 (1.25)
Age (years) (%)		
<30	12 (60)	23 (53)
31–40	5 (25)	9 (21)
>41	3 (15)	11 (26)
Sex (%)		
Male	11 (55)	30 (70)
Female	9 (45)	13 (30)
RACE (%)		
White European	11 (55)	32 (74)
Black (UK)	1 (5)	1 (2)
Black African	3 (15)	1 (2)
Black Carribean	2 (10)	4 (9)
Asian other	3 (15)	5 (12)
Men who have sex with men (MSM) (% of men)	5 (45)	11 (37)
Symptoms signs of GC (%)	13 (65)	25 (58)

P46 PELVIC INFLAMMATORY DISEASE DIAGNOSIS, TREATMENT AND CONTACT TRACING IN A FULLY INTEGRATED SEXUAL HEALTH CENTRE

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Background BASHH guidelines on pelvic inflammatory disease (PID) were updated in 2011. A recent national audit of PID management in UK GUM clinics suggested that adherence to BASHH guidelines in terms of treatment regimen and partner notification was below national standards. Our GUM service has recently integrated with family planning to form a fully integrated sexual health centre. We were interested to see how our PID management compared to national findings.
Aims To determine whether our management of PID was in line with current UK guidance.
Methods A prospective audit of all cases of PID seen at our sexual health centre over a 6-month period was performed by asking all clinicians to report suspected cases of PID and by review of our clinic database to identify any further patients treated for PID. The audit determined criteria for PID diagnosis, treatment regimen, follow-up plans and partner notification.
Results There was some variation in criteria used to make a clinical diagnosis of PID. However, all patients treated for PID complained of lower abdominal pain and most had adnexal tenderness or cervical excitation on examination. Most women were treated with ofloxacin and metronidazole although there was variation in the duration of metronidazole therapy prescribed. All women were offered a follow-up appointment, most of which were 1–2 weeks from initial diagnosis. Partner notification was poor and fell below current UK targets.
Discussion Unfortunately, despite the benefits of skill sharing of family planning and GUM professionals within a fully integrated sexual health centre our management of PID in terms of drug regimen, follow-up and partner notification did not meet recommended national standards. Workshops on PID have been built into our protected teaching time to explore reasons for non-adherence to current national guidelines and to try and improve our standards of care.

P47 SYSTEMATIC RECALL VS STANDARD CARE, ADDRESSING THE INCREASED RISK OF RE-INFECTION IN PATIENTS PRESENTING WITH GONORRHOEA

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Background Gonorrhoea is of increasing concern in UK, with the gonococcal resistance to antimicrobials surveillance programme reporting high levels of resistance to antibiotics. Prior history of gonorrhoea is a strong predictor of current infection, supporting the concept of a group of "core transmitters." The US Center for Disease Control advises retesting of patients with gonorrhoea 3 months after treatment to identify repeat infections. Current UK guidelines only recommend a test of cure at 2–4 weeks.
Aim To assess the feasibility, acceptability and effectiveness of routine retesting at a 3-month interval, in UK sexual health clinic attendees diagnosed with gonorrhoea.