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.

Methods Attendees between November 2010 and June 2011 diagnosed with gonorrhoea were offered retesting 3–6 months after treatment, with a subsequent reminder to attend (recall arm). Re-attendance rates and frequency of gonorrhoea diagnosis were compared to a historic group who attended between October 2006 and April 2007, controlling for age, sex, sexual orientation and history of STI (control arm).
Results 242 patients were assessed in the recall arm. 95 (39%) re-attended within 6 months of initial attendance and 15 (6%) were positive for gonorrhoea. Of 202 controls, 44 (22%) re-attended within 6 months and 12 (6%) tested positive for gonorrhoea. Being actively recalled increased re-attendance at the clinic (β=2.2, p=0.001) but did not detect additional cases of gonorrhoea (β=1.2, p=0.9).
Conclusion These results strongly suggest that the CDC recommendation for re-testing for infection after 3 months is not an effective approach for unselected patients with gonorrhoea in the UK.

P48 YEARLY TRENDS FOR THE INTERNET RECRUITMENT PROGRAM, HTTP://WWW.IWANTTHEKIT.ORG—WHAT HAPPENED TO THE STI PREVALENCE?

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Background The iwantthekit (IWTK) internet recruitment screening program began in 2004 and offered an opportunity to determine trends in prevalence for women and men were screened for STIs.
Objectives To determine significance in trends for STIs for the population accessing screening over time.
Methods Participants were recruited via the internet to request home collection kits and to collect either vaginal or penile swabs at home with subsequent mailing to a laboratory for screening for chlamydia (CT), gonorrhoea (GC), and trichomonas (TV) by NAATs. Prevalence for women and men were calculated by year and race for 2004–2011 for each organism. Linear regression analysis was performed to determine significance of temporal trends in gender-, STI-specific prevalence controlling for annual demographic composition of participants.
Results 3363 women were screened for CT and GC from 2004 to 2011; TV screening was added in 2006 (N=2692). From 2006 to 2011, 1370 men were screened for CT, GC, and TV. Prevalence varied: CT: 5.5%–10.6%; GC: 0.3%–2.7%; TV: 5.8%–13.3% for females and CT: 8.0%–15.4%; GC: 0.7%–1.9%; TV: 0.8%–12.4% for males. Most users were from Maryland (70.1%). The only statistically significant linear downtrend by year was CT prevalence in male participants <25 yr from 23.1% in 2007 to 12.5% in 2011, which was 2.4%/yr (p=0.012); while the prevalence in male ¡Ý25 years remained relatively stable from 6.2% in 2007 to 5.5% in 2011 (p=0.911). The remainder of STI prevalences in females and males did not show a downward linear trend by calendar year. GC prevalence in females was significantly correlated with the per cent of Black participants (p=0.030), while TV prevalence in females was positively associated with the number of participants <25 yr (p=0.032).
Conclusions IWTK attracted participants with high-risk sexual behaviours to use home collection for STI testing. Prevalence by year and by organism, for the most part, did not show a significant downward trend.

P49 OTOSYPHILIS: MISSED OPPORTUNITIES FOR EARLY TREATMENT?

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Background Otosyphilis (OS) is one of the few reversible causes of hearing loss. Audiological symptoms and positive syphilis (SP) serology can be diagnostic of OS. Hearing outcome after treatment is poor and evidence for optimal management is lacking.
Aim To identify how OS is managed in our unit.
Method Case collection and notes review.
Results Seven (6 male, 1 female) patients (pts) with OS were identified between 2007 and 2011, of median age 34 yrs. Of these 7 pts: 6 (86%) had secondary stage and 1 (14%) late stage SP; 6 (86%) were coinfected with HIV (2 testing HIV+ at SP diagnosis); all presented with deafness (bilaterally in 3 pts); all had other symptoms of SP (commonly rash (4, 57%) and ocular involvement (3, 43%)). Of 6/7 pts consenting to lumbar puncture, neurosyphilis was probable in 1 (17%), excluded in 2 (33%) and considered possible in 3 (50%) pts. Median time from audiological symptoms to treatment was 2 months (range 2 days to 6 m). Four (57%) had previously visited a health care professional who failed to diagnose OS. Six (86%) and 5 (71%) pts received a neurological regimen and steroid cover respectively. Overall, hearing improved in 3 (43%) and stabilised in 4 (57%) pts. An improved audiological outcome was seen in 2/3 (67%) pts receiving early treatment (within 1-month of hearing loss) vs 1/4 (25%) of those receiving late treatment and in 3/6 (50%) pts receiving a neurological regimen vs 0/1 pts receiving standard treatment. Median time to treatment was shorter in pts with established HIV infection (2 months) than those testing HIV+ at SP diagnosis or testing HIV neg (3.5 months).
Conclusion This small study identifies a delay to treatment in many cases. Early treatment and treating with a neurological regimen may improve outcome. HIV+ pts may have more regular SP testing, reducing the delay to treatment. OS is uncommon, but with increasing rates of SP nationally, we must be alert to its manifestations and promptly initiate treatment.

P50 CHLAMYDIA SURVEILLANCE IN THE USA: THE NEED FOR NEW STRATEGIES

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Background Preventing infertility through the prevention and control of chlamydia is a priority in the USA. Valid and timely surveillance data on chlamydial infections are needed to estimate disease burden, monitor trends, and inform and evaluate chlamydia prevention strategies.
Methods We assessed the strengths and weaknesses of the US chlamydia surveillance system, including notifiable disease reports, opportunistic data from screening programs, and national surveys.
Results Notifiable disease report data are heavily influenced by changes in screening coverage, empiric treatment, diagnostic test technology, and reporting practices. Although test positivity data from federally-funded screening programs can account for the number of tests conducted, data are affected by changes in clinics participating in the program, differences in screening criteria between clinics, and demographic shifts in clinic populations. National survey data are representative of the general population and estimate point prevalence. However, data are not timely and