

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 ($\beta=2.2$, $p=0.001$) but did not detect additional cases of gonorrhoea ($\beta=1.2$, $p=0.9$).

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.

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YEARLY TRENDS FOR THE INTERNET RECRUITMENT PROGRAM, [HTTP://WWW.IWANTTHEKIT.ORG](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 ≥25 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.

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OTOSYPHILIS: MISSED OPPORTUNITIES FOR EARLY TREATMENT?

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Background Ootosyphilis (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 coinfecting 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.

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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