Conclusions Equivocal reports introduce delays to patient management while the risk of unnecessary antibiotic therapy appears acceptable to most patients. The cobas 4800 CT/NG PCR screening assay can achieve UK testing standards (PPV >90%) in extragenital swabs and low prevalence gonorrhoea population without supplementary tests. A patient-led confirmation algorithm is proposed.

P54 OCULAR SYPHILIS: LESSONS FROM 4 DECADES OF EXPERIENCE

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Background Ocular syphilis can affect most eye structures and can be the result of congenital and acquired infection. Many ocular signs are not specific to syphilis and it can be difficult to make the diagnosis.
Aim This study aims to investigate the epidemiology of ocular syphilis presenting to an oculogenital clinic.
Method Retrospective case notes review of ocular syphilis cases seen between 1965 and 2011. Of 307 cases with ocular signs and positive treponemal serology, 85 cases with a history of yaws were excluded, leaving 222.
Results Of the 222 cases, 93 (42%) were late congenital (CS), and 129 (58%) were acquired (AS). Of the CS cases, the mean age was 47.5 (range 7–86), 37 (40%) were male, of whom 1 was MSM. 55 (59%) were from the UK, 19 (20%) from the Caribbean, 9 (10%) from Europe. Eye signs were as follows: interstitial keratitis 73, anterior uveitis 23, posterior uveitis 10, panuveitis 3, Argyll-Robertson pupils (ARP) 1 and optic neuritis (ON) 1. Of the AS cases, the mean age was 50.9 (range 17–85), 99 (77%) were male, of whom 15 were MSM. 31 (24%) were from the UK, 15 (12%) from Europe, 51 (40%) from the Caribbean and 16 (12%) from Africa. 17 (13%) were early syphilis (secondary/early latent) and 112 (87%) were late latent or tertiary syphilis. Eye signs were as follows: anterior uveitis 63, posterior uveitis 21, panuveitis 13, optic atrophy 9, ON 8 and ARP 5. 35 (38%) of CS cases and 8 (6%) of the AS cases had extra-ocular signs of syphilis. Treatment was with a neurosyphilis regimen. STI screen were offered to all patients. Concomitant STIs are shown in the abstract P54 table 1.

Abstract P54 Table 1 Number of patients presenting with concomitant STIs

	Congenital	Acquired-early	Acquired-late
Gonorrhoea	2	3	9
Chlamydia	2	2	7
NSU	1	0	3
PID	6	0	0
Herpes	2	1	4
HIV	0	1	1
TV	2	1	5
Scabies	3	0	1
Warts	0	4	1
Any STI	17	7	25

Conclusions (1) Ocular syphilis has varied presentations. (2) Screening for other STIs is important even in late CS and AS. (3) Ocular syphilis can be the only sign of syphilis: clinicians should consider syphilis as a cause of undiagnosed eye signs.

P55 EVALUATION OF NAAT AND POCT FOR DETECTING *TRICHOMONAS VAGINALIS* INFECTION IN WOMEN AT A LONDON SEXUAL HEALTH CLINIC

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Background TV is a common infection in our clinic, but the true prevalence is likely to be higher since microscopy-the current diagnostic test has a low sensitivity. Nucleic Acid Amplification (NAAT) and Point of Care Tests (POCT) are commercially available and are reported to have much higher sensitivities. To our knowledge this is the first study to evaluate four different tests for TV in a London Clinic.
Aim To evaluate the clinical utility of NAAT and POCT compared to microscopy and culture.
Methods All symptomatic women who presented to the clinic on Monday and Tuesday from September 2011 were invited to participate in the study. Swabs for a validated in-house NAAT, POCT (*OSOM Genzyme Diagnostics*) and culture using *TV In-pouch* culture system were taken. Technicians processing the POCT, NAAT and cultures were blinded to all other results.
Results A total of 247 symptomatic women were recruited over a 6-month period. 21 (8.5%) tested positive on culture, 22 (9%) on POCT and NAAT, 9 (3.6%) on microscopy. Using culture as the reference standard the sensitivities/specificities were: POCT 100% [95% CI 84 to 100]/99.6% [95% CI 97.5 to 99.9], NAAT 95.2% [95% CI 76 to 99.9]/99.1% [95% CI 96.8 to 99.9], microscopy 42.9% [95% CI 22 to 56]/100% [95% CI 98.4 to 100] and prevalence 8.5% [95% CI 5.4 to 12.8]. Using NAAT as the reference standard the sensitivities were: culture 90.9% [95% CI 71 to 98.9], POCT 95.5% [95% CI 77 to 99.9], microscopy 36.4% [95% CI 17 to 59] and prevalence 8.9% [95% CI 5.7 to 13.2].
Conclusions The sensitivity of POCT and NAAT were as anticipated much greater than microscopy alone, resulting in a prevalence over double than previously estimated. Molecular methods for detecting TV infection in this population would diagnose a significantly greater number of women with TV. Clinics with high rates of TV may benefit from using POCT with the advantage of a rapid turn-around result over NAAT.

P56 DOES CEFTRIAXONE PLUS AZITHROMYCIN REDUCE GONORRHOEA RETREATMENT COMPARED TO CEFTRIAXONE PLUS DOXYCYCLINE? A RETROSPECTIVE COMPARISON

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Background Currently, the combination of Ceftriaxone (CTX) and Azithromycin (AZM) is favoured over CTX and Doxycycline (DOXY) for treatment of uncomplicated *Neisseria gonorrhoeae* infections (GC) in both the UK and the USA.
Aims/Objectives To retrospectively compare retreatment rates between patients receiving CTX + AZM and those receiving CTX + DOXY.
Methods We analysed clinic records for all patients treated for GC at either of Baltimore's public STD clinics between January 2004 and June 2011 and measured time to retreatment from the date when the CTX regimen was administered. Patients were censored 2 years after treatment was received or on 30 September 2011, whichever came first. Kaplan–Meier curves and Cox Proportional Hazards models were used to compare retreatment rates.

Results Overall, 4134 patients were treated for GC with CTX + AZM (n=1185, 31.5%) or CTX + DOXY (2830, 68.5%), 406 (9.8%) of whom were retreated. Treatment regimen was not related to time to retreatment, even when controlling for risk factors associated with re-infection (adjusted HR 0.88, 95% CI 0.70 to 1.14); a sub analysis of patients who were retested for GC within 90 days of CTX treatment also found no difference in retreatment rates across treatment regimens. Other factors that independently increased the risk of retreatment included: being a man who has sex with men, aged <25 years, having a history of GC or chlamydia, and reporting >2 sex partners within the past 6 months at time of CTX treatment. Patients treated after Expedited Partner Therapy (EPT) became available were 30% less likely to be retreated regardless of whether the patient themselves received EPT.
Discussion/Conclusions Compared to CTX + DOXY, CTX + AZM did not provide enhanced efficacy in this population. EPT is associated with a reduction in retreatment rates in the population even among those who did not receive EPT themselves.

P57 TO TREAT OR NOT TO TREAT

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Background The BASHH guidelines recommend offering full STI screening and epidemiological treatment to sexual contacts of those with confirmed Chlamydia infection. However, many patients attend sexual health clinics reporting to be contacts of Chamydia, but unable to give details of the index case. The management of these unverified Chlamydia contacts is unclear. Most clinics pragmatically treat contacts during their first visit; however some clinics may choose to wait for results before treating. This study was aimed at establishing current practice of management of Chlamydia contacts both verified and unverified, in a large inner city GUM clinic.
Method Health care practitioners were requested to fill in a questionnaire when patients who reported to be contacts of *Chlamydia trachomatis* attended the clinic over a 6-month period.
Results 59 Questionnaires were returned. In 76% (45/59) of patients attending as contacts of Chlamydia, details of index case could not be verified. 62% of these patients were asymptomatic and 56% (25/45) treated on first visit. Subsequently 27% (12/45) had a positive Chlamydia test whereas 36% of Chlamydia tests were positive in the cases where details of index case could be verified. The difference the positive rates of verified and unverified Chlamydia contacts is not significant (p=0.51).
Conclusion Despite acknowledging that our numbers are small, a high percentage of unverified Chlamydia contacts had positive Chlamydia tests. Given this we recommend that all patients attending STI clinics reporting to be contacts must be treated at first visit to avoid complications, losses to follow-up and decrease patient anxiety.

P58 NUCLEI ACID AMPLIFICATION TESTS (NAAT) FOR *TRICHOMONAS VAGINALIS*: SHOULD THEY CHANGE WHO WE SCREEN FOR INFECTION

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Background UK national guidelines recommend screening for *Trichomonas vaginalis* (TV) in symptomatic women and men with persistent urethritis using culture +/− wet mount microscopy. Screening of asymptomatic patients is not recommended due to the low prevalence of infection and low sensitivity of available tests. TV NAAT has been shown to have high sensitivity (96.7%) and specificity (97.5%) with the potential to increase the detection rate of TV infections.
Objectives To determine an accurate prevalence of TV infection in a UK STI clinic using the TV NAAT and to characterise the risk factors associated with TV infection to inform an appropriate screening strategy.
Method Over a 6-week period, unselected patients presenting to the UK STI clinic with a new clinical episode were offered a TV NAAT test (Gen Probe transcription-mediated amplification) as part of their sexual health screen. A vaginal swab was taken from women, and men provided either a urethral swab or urine sample. Information on demographics and clinical presentation was collected on a paper proforma. All data analysis was performed using SPSS V.19.
Results 3546 patients were seen in the study period of whom 98.8% provided a sample for TV NAAT testing. The prevalence of TV infection was 21/1483, 1.4% (95% CI 0.9% to 2.2%) in male patients and 72/2020, 3.6% (95% CI 2.8% to 4.5%) in female patients. The rate of TV positivity was higher in Black Caribbean patients compared to Caucasian patients in both men (5.4% vs 0.1%, p<0.001) and women (9.0% vs 1.2%, p<0.001). There was no significant difference in TV positivity across the age groups. In comparison to culture, TV NAAT detected an additional 24% of infections in symptomatic women.
Discussion TV NAAT is a more sensitive test. The prevalence of TV in UK STI clinic population is still low compared to USA. Given the higher cost of NAAT, screening of all clinic patients is unlikely to be cost-effective but may be worth considering in high risk subgroups.

P59 IMPROVING MANAGEMENT OF PELVIC INFLAMMATORY DISEASE BY USING A SIMPLE TICK-BOX STICKER

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Background Pelvic Inflammatory Disease (PID) is a common condition with a reported 1:50 sexually active women in the UK developing it annually. An estimated 1:5 will consequently become infertile. Use of the 2011 BASHH guidelines provides an excellent tool in improving uniformity in treatment and advice provided.
Aim To assess improvement in care from two cohorts of patient's with PID attending a District General Hospital clinic, at two points, 3 years apart by introduction of a PID tick-box sticker.
Method Using a BASHH guideline based proforma, data were recorded and compared between 2 cohorts, the 1st from June to December 2008 (27pts), the 2nd from 2011 (25pts).
Results In 2011: STI detection was increased at 48%, from 37% previously, reflecting national trends. 88% received 2 weeks of metronidazole and doxycycline (12% had erythromycin due to risk of pregnancy). None had ceftriaxone as per local guidelines based on this and an additional audit, which revealed very low prevalence of infection with *Neisseria gonorrhoeae* in the local PID population. Improvements with the introduction of the sticker included number of pregnancy tests performed—80% up from 26% and documentation of provision of written information which rose from 3.7% to 88%. 60% saw the HA at their clinic visit compared to 44% in 2008. Partner notification rates were unaffected with 51.6% of male contacts screened with a STI detected in 44% as opposed to 67% in 2008 with a STI in 37%. *N gonorrhoeae* was not identified in any presenting woman, nor any screened contact in 2011 and in only one contact in 2008.
Conclusion Introduction of a simple measure such as a PID sticker can aid documentation and adherence to correct management. Striving to improve better partner notification with subsequent