

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

doi:10.1136/sextrans-2012-050601c.57

J Thomas,* T Mathew, P B Carey. *Royal Liverpool University Hospital, Liverpool, UK*

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 Chlamydia, 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

doi:10.1136/sextrans-2012-050601c.58

A Ng,* J Ross. *Whitall Street Clinic, Birmingham, UK*

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

doi:10.1136/sextrans-2012-050601c.59

N B Connolly,* S Hamer, M Ward, J Mellor, O McQuillan. *Trafford Centre for Sexual Health, Manchester, UK*

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