asymptomatic patients. The methods established could also be used in comparisons in clinical studies.

Abstract P71 Table 1 TV diagnosed according to test

Assay	Aptima ATV TMA	WT In-house PCR	TV RT PCR	TV confirmation PCR
Number of positives	18 (18.75%)	17 (17.9%)*	17 (17.9%)	17 (17.9%)

*One sample was a low level positive/negative, but this was also positive on Aptima.

P72 MICROSCOPY AND CULTURE FOR *TRICHOMONAS VAGINALIS* (TV): ARE BOTH TESTS REQUIRED AND SHOULD TEST OF CURES (TOC) BE PERFORMED ROUTINELY?

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Background Testing for TV has changed locally in recent years dependant upon whether the woman has symptoms. Microscopy and culture are now only performed in symptomatic women or in contacts of TV. All patients diagnosed with TV must be seen by the Health Advisers to discuss partner notification and to arrange a TOC within 2 weeks.
Aim To ascertain if both microscopy and culture remain warranted for symptomatic women and those attending for TOC or whether microscopy alone is sufficient for diagnosis. To compare audit findings with previous audits using BASHH auditable standards.
Method Case notes of patients diagnosed with a KC60 code of C6A between 1 October 2009 and 31 October 2010 were reviewed.
Results A total of 58 patients were included in the audit pertaining to 65 episodes. Largest ethnic group was Black/Black British Caribbean (34%). The majority (93%) were symptomatic. Nine (14%) patients had positive microscopy and negative culture, 10 (15%) had negative microscopy and positive culture and 46 (71%) had positive microscopy and culture results. The majority (97%) received Metronidazole therapy. 43 (74%) saw a Health Adviser after initial diagnosis. Almost all (88%) had documented partner notification and 27 contacts attended for treatment. 46 (79%) attended for TOC and of these 36 (78%) attended within 2 weeks. Of the 46 attending for TOC, 42 (91%) were symptomatic but only five (12%) were TV positive on TOC. Auditable standards comparison (see abstract P72 table 1).
Discussion Overall the results from this audit have demonstrated an improvement in respect to previous audits in line with BASHH auditable standards. Findings related to microscopy and culture results do not appear to demonstrate a significant risk in missed diagnoses and those who were microscopy negative (subsequently culture positive) had Hay and Ison Grade 2/3 and treatment with Metronidazole. In skilled hands, microscopy alone may be sufficient to diagnose TV in those attending with symptoms.

P73 A REVIEW OF DIAGNOSTIC TOOLS USED IN THE DETECTION OF *NEISSERIA GONORRHOEAE* (GC) IN WOMEN ATTENDING A LONDON SEXUAL HEALTH CLINIC (SHC)

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Background Near-patient microscopy (NPM) has poor sensitivity in the identification of GC in women, with NPM of urethral (Ur) smears no longer recommended by BASHH.
Aim To review the diagnosis of GC in women attending a London SHC and assess the relative merits of NPM, culture and Nucleic acid amplification tests (NAATs) in detecting GC.
Method Female GC diagnoses from 1 January 2008 to 30 June 2011 were identified from the GU Medicine Clinic Activity Dataset and case notes reviewed. The results and sites of GC tests taken, were recorded. Slides stated as "suspicious" for GC on NPM were counted as positive. GC was cultured on selective medium. The Beckton Dickinson Probe Tec Strand Displacement Assay (dual NAAT for GC/CT) was used for endocervical (Cx) specimens from 22 June 2009.
Results Notes were available in 334/369 (91%) of cases (317 women): median age 20 years (range 13–53); 92/334 (28%) White British; 87/334 (26%) Black Caribbean; 219/313 (70%) symptomatic; 160/321 (50%) had a previous STI; 42/317 (13%) had a history of GC; 58/334 (17%) were GC contacts. 289 cases had Ur/Cx cultures taken: 30 (10%) were positive on Ur culture; 148 (51%) on Ur and Cx culture; 88 (30%) on Cx culture. 11/142 (8%) Cx NAATs performed were negative for GC: 6/11 were positive on Ur culture; 5/11 on pharyngeal culture/NAAT; 1/11 on Cx culture. 104/125 (83%) with positive Cx NAATs were positive on Cx culture. 42 were diagnosed with GC on vaginal NAATs. 135/330 (41%) were also diagnosed with *Chlamydia trachomatis* (CT) (see abstract P73 table 1).
Conclusion Cx NAAT was more sensitive than culture in detecting GC; supplementing Cx NAAT with Ur culture will reduce the potential for missed cases. Our data shows a poor sensitivity of Ur

Abstract P73 Table 1 Results of NPM for culture positives

	Urethral	Endocervical
NPM positive	29 (12 Cx NPM negative)	29 (12 Ur NPM negative)
NPM negative	99	138
NPM not done	49	69
Sensitivity NPM	29/128 (23%)	29/167 (17%)
False positives*	3	13

*NPM was positive for GC but samples were culture negative

Abstract P72 Table 1 Comparison of auditable standards and rate

Auditable standards	BASHH	Local	Audit 2011 n=58	Audit 2006 n=94
Patients diagnosed with TV should receive treatment with Metronidazole—either 400 mg twice daily 5/7 or 2 g stat	100%	–	97%	96%
Symptomatic female patients at presentation should have a TV wet mount and culture	–	100%	100%	98%
Those diagnosed with TV infection should have contact tracing performed	100%	–	88%	71%
One or more traceable contacts should treated within 1 month	60%	–	47%	33%
Women with TV on cervical cytology should be offered confirmation of diagnosis with a vaginal swab before treatment and offered	100%	–	100%	–
Patients should return for a TOC within 2 weeks of treatment	–	50%	78%	71%