Results Of the planned 1400 MSM, 99 (53 HIV+) have been recruited. Two equivocal results were excluded from analysis. Some of the questionnaire data were missing. 80%(73/91) were symptomatic and 60% (57/96) reported unprotected anal sex in the last month. The prevalence of CT and/or NG infection was 35% (95% CI 26% to 45%), CT alone 14% (95% CI 8% to 23%) and NG alone 21% (95% CI 13% to 30%). The sensitivity and specificity of PS vs SOC to detect CT/NG is 88% (95% CI 72% to 96%) and 100% (95% CI 93% to 100%), respectively (abstract P98 table 1). PS failed to detect four NG cases (3 pharynx, 1 rectum). MSM reported confidence (n=74, 86%) and willingness (n=75, 88%) to take their own samples (see abstract P98 table 1).

Abstract P98 Table 1 Sensitivity and specificity of pooled samples according to test

	Number positive (%) SOC testing [95% CI]	Number positive (%) PS testing	Sensitivity % [95% CI]	Specificity % [95% CI]
CT &/ or NG* (*CT&NG, n=4)	34 (35) [26 to 45]	30 (88)	88 [72 to 96]	100 [93 to 100]
CT	14 (14) [8 to 23]	14 (100)	100 [73 to 100]	100 [95 to 100]
NG	20 (21) [13 to 30]	16 (80)	80 [56 to 93]	100 [94 to 100]

Discussion Pooling specimens in MSM offers the potential for significant savings and improved access to testing. Missed infections may be due to sampling error or low organism load. The evaluation of this strategy continues.

P99 SOCIO-DEMOGRAPHIC AND BEHAVIOURAL CHARACTERISTICS OF MEN WHO HAVE SEX WITH MEN (MSM) AND HETEROSEXUALS INFECTED WITH GONORRHOEA

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Background As well as monitoring antimicrobial resistance, the enhanced Gonococcal Resistance to Antimicrobial Surveillance Programme dataset can be used to understand the epidemiology of gonococcal infection.
Objective To explore socio demographic and behavioural characteristics of MSM (HIV positive and negative) and heterosexuals (male and female) infected with gonorrhoea.
Methods Demographic and behavioural data from Gonococcal Resistance to Antimicrobial Surveillance Programme, collected annually between July and September 2005–2010 from 26 sentinel GUM clinics were analysed.
Results Of 9239 gonorrhoea cases, 3089 (36%) were in MSM, of whom 861 (28%) were HIV positive; 5588 in heterosexuals, of whom 3012 (54%) were men. Predominantly of white ethnic background, HIV positive MSM (mean age 36 y) were older than HIV negative MSM (mean age 30 y). A higher proportion of HIV positive than negative MSM were co-infected with another STI (OR=1.6, 95% CI 1.3 to 1.9), mainly chlamydia (18% vs 15%) or syphilis (5% vs 2%). HIV positive MSM were also more likely (OR=1.5, CI 1.3 to 1.8) to report rectal gonococcal infection. Over a quarter of HIV positive MSM reported ≥6 sexual partners in the past 3 months compared to 18% of HIV negative MSM. Within the heterosexual population, higher proportion of women than men were of white ethnic background (74% vs 43%) and <25 y (72% vs 47%). Compared to heterosexual men, women were more likely to be co-infected with another STI (OR=1.5, CI 1.4 to 1.7) primarily chlamydia (41% vs 35%). Nearly two-third of heterosexual men reported ≥2 sexual partners in past 3 months while most women (64%) reported one or no sexual partners.
Conclusion Gonorrhoea is concentrated amongst specific population sub-groups. Our analysis indicates that these groups are at high risk of contracting and transmitting other STIs as well as HIV, and underlines the need for targeted interventions.

P100 ASSESSMENT OF BACTERIAL SEXUALLY TRANSMITTED INFECTION (STI) SCREENING FOLLOWING SEXUAL ASSAULT

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Background *Chlamydia trachomatis* and *Neiserria gonorrhoea* screening following sexual assault is undertaken primarily for sexual health purposes but can potentially facilitate criminal investigation in cases of penetration at sexually naive sites. Antibiotic prophylaxis at first attendance (within 7 days of the assault) is not routine but may be given when the return for screening is unlikely.
Aim To improve bacterial STI screening and management in complainers attending our sexual assault referral centre (SARC).
Objectives To determine if complainers were adequately screened for bacterial STIs and if communication with health professionals regarding repeat screening was adequate.
To review prophylactic antibiotic use.
To review the forensic significance of STI screening.
To identify factors which may improve the uptake of screening.
Methods 100 case records were reviewed and information relevant to our objectives extracted. Six cases were excluded.
Results 81% had a STI screen taken at presentation. Only 13% returned for repeat screen after incubation, confirming Chlamydia in two cases. All but one repeat screen correlated to the site of exposure. GPs were informed of the need for a repeat screen in 74% of cases. 59% had an alert sited on their sexual health record highlighting the need for a repeat screen. Antibiotic prophylaxis was given in 25 cases with reasons documented in only 4.
Discussion and/or Conclusion STI screening post sexual assault may be improved through better communication with complainers and other healthcare providers. Improvements to communication methods and training are required to facilitate this. The concern of emerging gonococccal resistance should be considered prior to administering prophylactic antibiotics. One individual, in whom there was no previous sexual contact and baseline screen was negative, had Chlamydia on repeat sample. This may be supportive of the assailant as the source of infection, indicative of the potential forensic role of STI screening.

P101 OLYMPIC OUTREACH: STI TESTING FOR CONSTRUCTION WORKERS

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Background It was feared that construction of venues for the 2012 Olympic and Paralympics Games would increase the burden of sexual ill-health in East London, due to a surge in migrant construction workers and commercial sex work.
Aims/Objectives We analysed data from outreach to construction sites at the Olympic Park and Village in Stratford, East London. We reported demographics, sexual risk factors and STI rates.
Methods An outreach team visited the Olympic site between February 2009 and October 2011. Clients completed a triage form about symptoms and sexual risk factors. Clients were offered nucleic acid amplification tests for Gonorrhoea and Chlamydia, using urine samples from men, and self-taken vulvovaginal swabs