nurses and clinical assistants. 20 patients had biopsies with 17/20, 85% providing a diagnosis. Of the 102 appointments 13% DNA; 11% cancelled by patient. Patients with vulval pain will be studied in more detail, data to follow (see abstract P160 table 1).

Conclusion The clinic was utilised by all staff groups, saw patients with a variety of conditions, predominantly dermatological and in the majority a definitive diagnosis was made. As well as improving patient management the clinic provided an excellent training opportunity and has resulted in improved links particularly with Dermatology and Histopathology.

Abstract P160 Table 1 Diagnoses of patients with complex GU problems

	Presentation	Diagnosis
Women (n=36)	Vulval pain-12	Vulvodynia-5, dermatitis-2, lichen sclerosis-1, atrophic vulvitis-1, BV-1, psychological-1, endometriosis-1
	Recurrent thrush-11	Recurrent thrush-9, C.glabrata-1, lichen planus-1
	Recurrent HSV-5	Recurrent HSV-4, apthous ulceration-
	Vulval itching-4	Lichen simplex-1, eczema-1, NAD-2
	Lichen planus-1	Lichen sclerosis-1
	Genital ulceration-1	Recurrent HSV-1
	Recurrent BV-1	Recurrent BV-1
	Vaginal discharge-1	Referred for TVUSS-1
Men (n=29)	Genital dermatoses-19	Zoons balanitis-8, lichenoid reaction-2, infective balanitis-2, eczema-2, seborrheic dermatitis-1, lichen planus-1, lichen sclerosis
	Persistent HPV-3	Persistent HPV-3
	Recurrent NSU-2	Chronic prostatitis-1; recurrent NSU-1
	AIN-1	Sebaceous cyst-1
	Folliculitis-1	Recurrent HSV-1
	Recurrent HSV-1	Recurrent HSV-1
	Haematoma-1	Resolved-1

P161 ROUTINE THREE-SITE NAAT TESTING IN MSM INCREASES PHARYNGEAL AND RECTAL DIAGNOSES OF CHLAMYDIA AND GONORRHOEA

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Background BASHH and Health Protection Agency guidelines acknowledge the increased sensitivity of Gonorrhoea (GC) NAAT testing compared to culture at extragenital sites. Chlamydia (CT) NAAT testing is also the test of choice at these sites. Routine three-site GC and CT testing in MSM was implemented at a genito-urinary medicine clinic using urethral, pharyngeal and rectal sites.

Objectives To compare the number of diagnoses of CT and GC before and after implementation of routine three-site NAAT testing for MSM.

Methods Records were reviewed of MSM testing positive for CT or GC from the urethra, pharynx and/or rectum between 1 January 2010 and 1 April 2010 and compared to the same 3-month period in 2011.

Results Number of cases: The proportion of GC cultures resistant to >1 antibiotic increased from 15.9% (18/113) to 41.8% (28/67), however cultures were only taken in 51.1% (138/270) of NAAT positive GC specimens (see abstract P161 table 1).

Discussion Pharyngeal GC, CT and rectal GC diagnoses increased with three-site NAAT testing, making the pharynx and the rectum the main sites of GC and CT infection. This increase in diagnoses has implications for clinical service provision. The increase in antibiotic resistance to GC has important clinical implications and when using routine three-site NAAT testing, cultures should always be taken prior to antibiotics being given.

Abstract P161 Table 1 Comparison of CT/GC diagnosed

	Q1 2010*	Q1 2011*
MSM attendances	4063	3975
MSM diagnosed	166	354
Diagnoses of CT or GC	199	494
CT (total)	81	225
CT Urethra	43	69
CT Pharynx	0	32
CT Rectum	25	113
LGV	13	11
GC (total)	118	269
GC Urethra	58	45
GC Pharynx	11	121
GC Rectum	49	103
MSM with infection at		
1-site	146 (88%)	258 (72.9%)
2-site	19 (11.4%)	80 (22.6%)
3-site	1 (0.6%)	16 (4.5%)
Diagnoses due to triple NAAT testing protocol (% of total):		322
Pharyngeal CT		32 (100%)
Rectal CT		106 (93.8%)
Pharyngeal GC		109 (90.1%)
Rectal GC		75 (72.8%)
Diagnoses treated due to triple-site NAAT testing (% of total)		234
Pharyngeal CT		20 (62.5%)
Rectal CT		78 (69%)
Pharyngeal GC		76 (62.8%)
Rectal GC		60 (58.3%)

*Q1 1st January to 1st April.

P162 STD PREVENTION ONLINE: A RESOURCE FOR THE STD/STI PROFESSIONAL COMMUNITY

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Background STDPreventionOnline.org (STDPO) is an online professional networking site for the sexually transmitted diseases/infections (STD/STI) work force, including researchers, clinicians, epidemiologists, disease intervention specialists, and programme managers. The site was developed by the internet and STD Center of Excellence, originally funded by a grant from the US Centers for Disease Control and Prevention (CDC) and currently sponsored by the American Sexually Transmitted Disease Association (ASTDA). The site was conceived as two-way clearing house of current STD/STI information and resources, where members could both download and upload information in a variety of formats including text, audio, and video files as well as blog and forum postings. Membership is free.

Objective To describe current users and usage of STPDPO.

Methods Descriptive statistics were obtained from embedded website metrics and Google Analytics©.

Results Since its inception in 2007, the site has registered 3500 members and the site's monthly newsletter has over 4000 subscribers. The predominance of site members (92%) live/work in the US, however a substantial number (n=258 as of January 2012) are non-US users with 47 countries represented. Most members (58%) work in STD/HIV programmes in state/local health departments, 13% in community or private clinics, 11% in a university setting, 8% in federal government, and 8% in community organisations. During 2011, the site logged 14 778 individual site visits and 61 205 page views; respectively 284 and 1177 per week. To date, over

1150 resources have been uploaded to the site which, have been downloaded over 40 000 times, an average of 35 downloads per resource. Topics related to internet use and online interventions are particularly popular, followed by clinical slide sets, and podcasts.
Conclusion During the 4 years of its existence, STDPO has demonstrated to meet a need in the STD/STI professional community for an interactive, two-way, clearing house of STD/STI-related information.

P163 PATIENT CHOICE: IS THE LOCAL HIV SERVICE PREFERRED?

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Aim To investigate the distance travelled by patient to a specialist HIV clinic in the Home Counties.
Methods Retrospective review of the electronic database of HIV patients attending the clinic from January 2011 to January 2012. Data on gender, ethnicity, sexual orientation, age and residential postcode was collected. The distance to our service was compared to that of the nearest available specialist clinic HIV clinic for each patient. Demographic data were also collected. χ^2 Tests were performed to compare categorical data.
Results 220 patients attended. The median age was 41 years, range 15–74. Our clinic was the closest HIV service for 89 (40%) patients. Of the 131 who selected our service in preference to their local service, 50% travelled up to 10 miles, 15% 11–20 miles, 14% 21–30 miles and 21% more than 30 miles. Interestingly the nearest service for 13 (10%) of these patients was an inner city teaching hospital. There was no significant difference in age, gender or sexual orientation between those who lived locally or travelled further, except for ethnicity. 66% of White British men and women were prepared to travel further for their HIV care compared to 51% for other ethnic groups (p=0.02) (see abstract P163 table 1).
Conclusions More than half our HIV patient cohort elected to travel further rather than utilise their local HIV services. The reason for this choice is unclear. However this study highlights the importance of considering patient choice when commissioning, planning and providing HIV services. Further research exploring the reasons for patient preference may aid our understanding of the aspects of HIV care that are particularly valued by our patients.

Abstract P163 Table 1 Demographics of HIV cohort

	Men (n=141)	Women (n=79)
Sexual orientation (%)		
Heterosexual	64 (46)	79 (100)
Bisexual	6 (4)	
Homosexual	71 (50)	
Ethnicity (%)		
White British	108 (77)	16 (23)
Black African	24 (17)	58 (73)
Other	9 (6)	5 (4)

P164 WHICH ASPECTS OF STIGMA ARE MOST IMPORTANT IN AN INTEGRATED SEXUAL HEALTH SERVICE?

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Background The stigma of sexual health services is pervasive and affects all user groups. It is likely to affect access to and satisfaction with the service. Reducing stigma has to be an essential aspect of improving sexual healthcare. Stigma has four domains: disclosure concerns, negative self-image, public attitudes and positive (non-stigmatising) aspects. It is currently not known which of these domains is perceived as most relevant by service users.
Objective To determine which aspect of stigma of the service was felt most intensely by service users in a level 3 integrated sexual health service (ISHS).
Method Application of a validated 15 item quantitative tool to assess stigma among 200 unselected patients attending an ISHS in outer London.
Results A total of 77 strong agreement with a statement describing stigma of the service were recorded. Of them nearly half were given in response to two statements: statement (S) 5: "I am careful whom I tell that I have been in this clinic" (14) and S 10 "I am concerned that I bump into someone I know when I am at this clinic" (16). No other statement attracted >6 positive strong responses. Of the 171 responses indicating a moderate stigma of the service 24 were given to the S1 "I won't tell anyone that I came to this clinic because I am concerned about their reaction". Statement 5 and S10 received 22 moderate agreements each while S6 "I worry that people who know that I have been here tell others that I have been to this clinic" attracted 17 moderate positive responses.
Discussion Our research indicates that disclosure concerns are the key source of stigma for the ISHS. Other aspects like self-image or public attitudes were less relevant. The high level of concerns expressed in S10 throws a new light on the issue of time spent in the waiting room. It suggests that waiting can be very stressful as stigmatising encounters are anticipated.

P165 GUM/HIV TRAINEES' EXPERIENCE AND TRAINING NEEDS IN THE MANAGEMENT OF PATIENTS DISCLOSING SEXUAL VIOLENCE

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Background Patients attending GUM clinics may disclose sexual violence. Are GUM/HIV trainees equipped to manage these cases?
Aim To assess the experience and training needs of GUM/HIV trainees in managing patients disclosing sexual violence (SV patients).
Method An e-survey was open to GUM/HIV trainees for 12 weeks from February 2011. Data were analysed in Excel.
Results Of the 158 current GUM/HIV trainees, 44 (28%) completed surveys. All respondents managed SV patients and 59% managed ≥ 1 SV case/month. Of these, 98% had seen females, 66% males, 73% 16–17 years/olds, 34% 13–15 years/olds, 5% under-13s. All respondents routinely asking about SV saw ≥ 1 case/month vs 50% of those who rarely/never asked. Confidence increased with frequency of seeing patients: 96% (25/26) seeing ≥ 1 SV patient/month felt confident vs 67% (12/18) seeing <1/month. Confidence in managing female, male and under-18 SV patients was reported in 86%, 79% and 58% respectively. In the six units with a dedicated SV clinic two trainees had worked in one, overall, 92% would have liked to. Similarly, 14% had worked in a Sexual Assault Referral Centre, 81% would have liked to. Respondents had trained in safeguarding children, adult SV, chain of evidence, vulnerable adults and domestic violence in 92%, 82%, 76%, 64%, 32% respectively. Abstract P165