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Aim To characterise the patients who were seen between 1998 and 2011 with a diagnosis of PD.

Method Retrospective case notes review of 18 identified cases with history and signs consistent with PD.

Results The mean age of the 18 patients was 42 (range 20–63); six were Caucasians, six were from Indian subcontinent, five Africans and one Caribbean. All except one gave a history of change in penis shape during erection: six had upward curvature, seven bent to the left, one to the right, two had shortening of penis/distal flaccidity and one had no change. Seven had pain on erection, 10 had history of a penile lump, five had erectile dysfunction and two had difficulty in penetration. The mean duration of symptoms before presentation to the clinician was 64.1 months (range 3 weeks to 264 months), none had a history of penile trauma, intracavernosal injection or Dupuytren's contracture. Of four who had an ultrasound scan of the penis, two were confirmed to have lumps consistent with PD. Of 12 who had primary treatment with colchicine for 2–12 months; three showed improvement in symptoms, three no change and six unknown outcome. Of two who had primary treatment with pentoxifyline for 1–11 months one showed improvement in symptoms and one unknown. Of three who failed to respond to colchicine and were then treated with pentoxifyline, a further one showed improvement.

Conclusion (1). 28% of cases had ED. (2). Overall, 33% of the patients had symptomatic improvement with treatment and none had worsened post treatment which is consistent with the findings of other studies.

P185 A PILOT PROGRAMME FOR THE UNDERGRADUATE TEACHING OF SEXUAL HEALTH USING INTERACTIVE DEMONSTRATION FOR EXPERIENTIAL LEARNING

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[1]B Flynn,* [2]I Fernando, [2]R Cochrane, [3]K Boyd, [4]B Allan. [1]*Genito-Urinary Medicine, Chalmers sexual health centre, Edinburgh, UK;* [2]*Chalmers sexual health centreEdinburgh, UK;* [3]*Palliative Care Unit, RIE;* [4]*Patient Co-ordinator, RIE*

Background In Edinburgh in May 2011, the GUM and FP/SRH departments integrated. A priority for the new service was reviewing and improving the undergraduate teaching offered in sexual health.

Aim To increase and improve undergraduate teaching, using experiential learning to develop the skills and attitudes essential for managing patients with sexual health needs.

Methods An OSCE format with interactive demonstration was chosen as the method to achieve these aims. Stations focused on effective communication and developing appropriate skills and attitudes. Three OSCE stations, based on common and important sexual health scenarios, were designed for interactive group work using simulated patients. The fourth station facilitated open discussion of sexuality and its implications for the well-being of patients. Four pilot sessions were run. Feedback questionnaires were given to students, facilitators and simulated patients. Strengths, weaknesses, and suggestions for improvement were requested. Participants were asked to score their level of enjoyment (from 1 to 10). Students also scored the course on how useful it was in meeting their educational needs (see abstract P185 table 1).

Results Feedback was extremely positive. Students felt the opportunity to practice their communication skills within sexual health consultations in a risk-free environment was the main strength. A request for "more scenarios" was the most commonly cited "weakness" and main suggestion for improvement.

Conclusion Following this successful pilot, the programme will now be regularly provided to the undergraduate medical students of Edinburgh. A similar model of teaching could be achieved at other departments, and is a successful way of delivering experiential learning in teaching resource limited settings.

Abstract P185 Table 1 Participant evaluation of interactive demonstration for experiential learning

	Simulated patient	Facilitator	Student
Number of returned forms	12	25	75
"Enjoyment" mean score (1–10)	8	8	8
"Useful" mean score (Students only)			8

P186 SHOULD NURSING STAFF IN SEXUAL AND REPRODUCTIVE HEALTH (SRH) CLINICS WEAR A UNIFORM?

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C Cunningham,* V Stewart, L Emslie, T Davis. *NHS Tayside, Dundee, UK*

Background The NHS Scotland dress code policy was implemented in 2008 with the introduction of a national uniform in 2010. Historically nursing staff within SRH clinics have chosen not to wear a uniform to create a less formal environment. Within the policy it is stated that boards should conduct a full risk assessment to ensure that local policy is appropriate for different categories of staff.

Aim To gather opinions from both patients and nursing staff about the impact of the introduction of the national uniform policy within the SRH service.

Methods A patient (n=224) and nursing staff (n=13) survey was undertaken over a 10-day period in January 2012.

Results The patient survey revealed that a minority (7%) of patients preferred that nursing staff wore their own clothes with the majority (54%) having no preference on staff dress code. The nursing staff surveys revealed that the majority work within a community health centre setting (46.2%) and were moderately happy with wearing a uniform (30.8%). Convenience was identified as a very important factor when choosing to wear a uniform (53.8%). The majority of staff agreed or strongly agreed that wearing a uniform made them more approachable (46.2%) and their role more identifiable to patients (71.6%) but they neither agreed or disagreed that it increased a patient's perception of their competency (46.2%) or enhanced professionalism (30.8%).

Discussion Although there was concern that the introduction of uniforms for sexual health nursing staff might interfere with the nurse–patient relationship this has not be realised.

P187 WORKFORCE PLANNING AND SAS DOCTORS: A CRISIS IN WAITING

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[1]J Lee, [2]E Carlin,* [3]A Robinson. [1]*Clayton Hospital;* [2]*King's Mill Hospital, Nottinghamshire, UK;* [3]*Mortimer Market Centre, London, UK*

Background The importance of medical workforce planning is well recognised but it is an inexact science and has usually concentrated on consultant and trainee numbers. The difficulties in planning are complicated by a lack of information on specialty and associate specialist (SAS) doctors.

Aims We sought to aid workforce planning by collecting data from the SAS workforce to enable broader sexual health service planning.

Methods A survey monkey questionnaire was devised and sent to all SAS doctors in sexual health who were known to the British Association for Sexual Health and HIV (BASHH) or its members.

The survey was open for completion for 3 months from March 2011.

Results In total, 227 SAS doctors (78% female, 22% male) completed the survey, 74% were on the new SAS contract, 44% as specialty doctors, 30% as associate specialists. Uptake was estimated at 40% on local assessment. According to the data in abstract P187 table 1, 1049−1253 genitourinary medicine (GUM) sessions/week are done by the respondents. Numbers are likely to be much higher given the estimated response rate. Significant numbers of HIV and sexual and reproductive health (SRH) sessions are also undertaken. Respondents indicated that 63% planned to retire within the next 15 years; 11% by 2013, 18% between 2014 and 2016, 20% between 2017 and 2022, 21% between 2022 and 2026, 29% were unsure when in the next 15 years they would retire.

Abstract P187 Table 1 Number of sessions performed by SAS doctors

	% of SAS doctors working these sessions
Number of GUM sessions/week	
1−2	20
3−4	20
5−6	17
7−8	15
9−10	18
≥10	3
Number of HIV sessions/week	
None	74
1−2	19
3−4	2
5−6	2
7−8	2
9−10	0.5
Number of SRH sessions/week	
None	49
1−2	24
3−4	10
5−6	7
7−8	4
9−10	5

Conclusion SAS doctors provide a major contribution to sexual health service work and given that 63% plan to retire within the next 15 years this is a crisis in waiting. Failure to take this data into account when planning for the future may mean that the crisis will become a reality.

P188 DO GENITOURINARY MEDICINE PHYSICIANS NEED TO KNOW ABOUT TROPICAL DISEASES?

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H Loftus,* E Powles. *Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK*

Background Many individuals presenting to genitourinary medicine (GUM) clinics have travelled or may have been born outside the UK. A number of tropical infections can present with genitourinary symptoms.

Aims To investigate how many cases of schistosomiasis were diagnosed in a GUM clinic over a 3-year period, whether they were treated according to the European Association of Urology guidelines for the management of urogenital schistosomiasis and whether treatment led to symptomatic improvement.

Methods All the schistosoma serology requests from our clinic in 2009−2011 were obtained and identified as positive, negative or equivocal results. The results were separated into those from our HIV clinic and those from GUM. The notes for all the positive and equivocal results were reviewed.

Results 182 tests were performed on 168 different individuals. 151 tests (83.0%) were carried out in HIV clinic, 31 tests (17.0%) in GUM. 4 (2.6%) of the tests carried out in HIV clinic were positive. 4 (12.9%) of tests carried out in GUM were positive. All positive results were non-British born males ranging in age from 28 to 42. All individuals with positive results had symptoms or signs that could have been attributed to urogenital schistosomiasis. Five of the 8 individuals had urine and stool sent to look for schistosome eggs, two had just urine analysed and 1 had neither. 6 individuals were referred to Infectious Diseases, two were managed in GUM. Seven of the 8 individuals were treated with praziquantel according to the guidelines. One individual declined treatment. Of those individuals treated, two had full resolution of signs and symptoms, three had partial resolution, one was followed-up in another department and one had no resolution of symptoms.

Discussion Genitourinary medicine physicians should consider a diagnosis of schistosomiasis in at-risk individuals when standard tests have not provided a diagnosis and resolution of symptoms.

P189 A NATIONAL MENTORING SCHEME WITHIN GENITOURINARY MEDICINE (GUM): IS IT WORKING?

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[1]C E Cohen,* [2]E Fox, [3]I Fernando, [4]J Dhar, [5]G Singh, [6]H Mullan, [7]E Street, [8]G Rooney. [1]*Chelsea & Westminster Hospital, London, UK;* [2]*Kent Community Health NHS Trust, Kent, UK;* [3]*New Royal Infirmary, Edinburgh, UK;* [4]*Leicester Royal Infirmary, Leicester, UK;* [5]*Cobridge Community Health Centre, Staffordshire, UK;* [6]*West Hertfordshire Hospitals NHS Trust;* [7]*Leeds General Infirmary, Leeds, UK;* [8]*Great Western Hospital, Swindon, UK*

Background Collaboration between BASHH and the Royal College of Physicians saw the development of a National mentoring scheme for newly qualified consultants in GUM. Mentors were recruited from senior GUM clinicians, and invited on a tailored mentoring course. On appointment, new consultants are offered and allocated a mentor for 18 months.

Objectives To determine the effectiveness of the mentoring scheme thus far.

Methods Voluntary interim questionnaires were distributed via Survey Monkey to mentor/mentee pairs who had joined the scheme for >3 months in January 2011. Responses were anonymous and quantitative data are presented.

Results 18 mentees and 17 mentors responded. The mean time from mentor allocation was 9.1 months (ranging 3−17). 80% of mentees found it easy to arrange their first meeting with their mentor, 72% had met their mentor between 1 and 4 times in person. Almost three-fourth (71%) felt they had received ample contact with their mentor, and in those who hadn't, time constraints and multiple competing service demands were repeatedly cited as barriers. Encouragingly, 69% of mentees felt the programme had helped them, with a further 25% responding, "not yet" as it was "too early in their mentorship". 93% of mentors responded they felt confident to support their mentee, and 79% perceived the relationship with their mentee was going well. Mentee feedback particularly favoured greater structure, including alerts to encourage meeting prioritisation and further guidance on what could be covered within mentorship.

Discussion The mentoring scheme, which now hosts 67 BASHH mentors and 41 mentees, is providing significant support to new GUM consultants. By developing a mentoring module with clear

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