

In the Netherlands the GP is the main care provider, also for sexual health. We investigated the trend in HIV-related consultations and testing practises in general practise in the last 2 decades.

**Methods** Within a nationally representative Dutch Sentinel General Practice Network we analysed HIV-related consultations from 1988–2009 using a questionnaire, in which patient's characteristics, the reason for consulting the GP, interventions and test results were recorded. Trends over time were calculated by multilevel analysis.

**Results** Time trend analyses show an increasing trend in HIV-related consultations and in the total number of HIV tests per 10,000 registered patients. Mean number of consultations doubled from 7 in 1988 to 14 consultations/10,000 population in 2009. Over the whole period, the number of HIV-related consultations was significantly higher in urban areas. The proportion of people high at risk, men who have sex with men (MSM) decreased. The proportion of HIV related consultations initiated by the GP increased from 11% in 1988 to 23% in 2009.

**Conclusion** In this 20-year period the policies around HIV testing changed drastically. HIV-related consultations, as well as provider initiated testing in general practise in the Netherlands increased, however slowly and mainly in low risk groups. Testing rates remain low. To prevent undiagnosed and late presentation of HIV infection, GP need to be more pro-active. New and innovative avenues, like opt-out and indicator-based testing, are needed in primary care as many test-opportunities among high risk groups and in high risk areas are missed.

**P5.031 CERVICAL CANCER AND STI SCREENING: A MUST IN THE ERA OF HIV/AIDS; INCREASING ACCESS FOR HIV INFECTED WOMEN THROUGH COMMUNITY OUTREACH SCREENING PROGRAMMES**

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**Background** Cervical cancer (CaCx) is the most frequently diagnosed cancer in Ugandan women. Forty five out of 100,000 women die annually due to limited availability of information, screening and treatment facilities, and poor health seeking habits. Over 80% of women present when in advanced stages. The risk of CaCx and STIs is doubled among HIV-infected women. STAR-E project instituted an integrated community outreach screening programme targeting WLHIV to accelerate early diagnosis, enhance timely referral for treatment and provide prevention education.

**Methods** Between March 2011 to April 2012, we reviewed records in 12 HIV care clinics to identify WLHIV at risk of STIs and CaCx. Key health workers were trained in STI diagnosis, and VIA/VILI screening methods. 50 PLHIV mobilisers were identified and oriented on risk factors, prevention, and early warning signs of CaCx and common STIs. During home visits, treatment support meetings and clinic days, and using pre-designed referral forms containing individual questionnaire they sensitised and mobilised community, and made referrals to lower level health centres where screening camps were set.

**Results** A total of 3500 WLHIV were sensitised and referred for STI and CaCx screening. 3450 (98.5%) were screened for the first time; 3405 (98.7%) tested VIA negative; 45 (1.3%) tested VIA positive and were referred for cryotherapy. of all women screened, 342 (9.9%) presented with different STIs, and were treated. 238 (69.6%) notified their partners who also accessed treatment. Only 20% of the women had heard about CaCx or sought help for any genital infections.

**Conclusion** Integrated outreach screening programmes are an important access point for people at high risk for both STIs and CaCx. It allows for not only the benefit of treating the STI, or identifying precancerous lesions, but for prevention education, identifying HIV-infected persons in need of care, and partner notification for STIs.

**P5.032\* DO FAST-TRACK ASYMPTOMATIC SCREENING PATHWAYS FOR MEN WHO HAVE SEX WITH MEN (MSM) LEAD TO MISSED OR DELAYED DIAGNOSES?**

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**Background** Within sexual health clinics in the UK MSM are usually examined with clinician-taken swabs. In an effort to increase access and encourage regular screening, a minority of clinics across the UK are now using a fast-track asymptomatic pathway for MSM with patient-taken swabs. However the consequences of not examining asymptomatic MSM remain unclear.

**Aim** Would the introduction of a fast-track asymptomatic screening pathway for MSM lead to missed diagnoses or delayed or withheld treatment?

**Method** This was a retrospective case note review of all MSM attending our UK level 3 sexual health clinic between July 2011 and July 2012. Clinical findings, diagnoses and treatments given to asymptomatic MSM were analysed further.

**Results** 476 of 920 MSM attendances were asymptomatic presentations, of which 21 (4.4%) had positive findings on examination. Perianal abnormalities were detected in 1% (peri-anal warts n = 4, skin tags n = 1). Genital abnormalities were penile warts (n = 2), epididymal cyst (n = 1), varicocele (n = 1), unretractable foreskin (n = 1), and 3 dermatological finding (dry meatus, abrasion on penis and penile erythema). Contact bleeding on proctoscopy was found in 2 (0.4%) patients, and 7 (1.5%) cases of non-specific urethritis (NSU) were identified. All 9 of these cases were negative for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*.

**Conclusion** Had the asymptomatic MSM attendances not involved examination, no significant clinical diagnoses would have been missed, or any treatment delayed or withheld. These findings suggest a fast-track asymptomatic screening pathway for MSM with patient-taken swabs could be introduced into UK sexual health clinics without concern. This in turn would increase sexual health screening for this high risk group. However consideration of missing perianal abnormalities in this group is needed as it may be of greater importance when compared to heterosexual males.

**P5.033 BRINGING HIV TESTING TO THE PEOPLE- BENEFITS OF MOBILE UNIT TESTING IN LIMA, PERU, 2007–2009**

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**Background** Mobile unit (MU) HIV testing is an alternative method of providing healthcare access. We compared demographic and behavioural characteristics, HIV testing history, and HIV prevalence between people seeking testing at a MU vs. fixed community clinic (FC) in Lima, Peru.

**Methods** Our analysis included men and transwomen (TW) in Lima ≥ 18 years old seeking HIV testing at their first visit to a community-based clinic's MU or FC from Oct. 2007–Nov. 2009. Behavioral characteristics, including HIV testing history, and HIV serostatus of the following populations were compared in MU vs. FC attendees: TW, men who have sex with men (MSM), and heterosexually self-identified men who have sex with men and women (MSMW).

**Results** A greater percentage of MU attendees self-identified as transgender (8% vs. 3% FC, p < 0.05) or heterosexual (52% vs. 15% FC, p < 0.05). MU and FC sites attracted similar proportions of MSMW (52% MU vs. 57% FC). MU attendees were more likely to

engage in compensated sex (10% MU vs. 4% FC,  $p < 0.05$ ), not use condoms during their last sexual encounter (64% MU vs. 45% FC,  $p < 0.05$ ), and be a first-time HIV tester (50% MU vs. 41% FC,  $p < 0.05$ ; see Table 1).

MU HIV prevalence was 5% (vs. 17% FC,  $p < 0.05$ ). Among first-time testers, HIV prevalence in both MSM and TW was not significantly different between MU and FC attendees (MSM: 13% MU vs. 19% FC  $p = 0.14$ ; TW: 41% MU vs. 50% FC  $p = 0.71$ ).

**Conclusion** MU testing reached large numbers of high-risk (TW/MSM) and potentially bridging (MSMW) populations engaged in unsafe sexual behaviours. MU HIV prevalence for MSM/TW first-time testers was similar to that of the FC, making MU outreach a worthy complement to FC testing. Further investigation into whether MU attendees would not otherwise access HIV testing is warranted to determine the impact of MU testing.

**Abstract P5.033 Table 1** Proportion of first-time HIV testers in MU vs. FC attendees stratified by sexual identity

	MU (n = 3,496)	FC (n = 1,854)	p value
MSM	164/590 (28%)	366/1,031 (36%)	< 0.05
TW	42/282 (15%)	4/50 (8%)	.19
MSMW	590/942 (63%)	88/154 (57%)	.20
Total	1,764 (50%)	765 (41%)	< 0.05

**P5.034 BRITISH CO-OPERATIVE CLINICAL GROUP (BCCG) PROJECT - HOW OFTEN ARE MEN WHO HAVE SEX WITH MEN (MSM) ADVISED TO ATTEND FOR REPEAT SEXUAL HEALTH SCREENING IN THE UK?**

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**Background** Within the UK rates of HIV, STIs, and sexual risk taking behaviours are increasing in MSM. 24% of new UK HIV diagnoses in MSM are recently acquired. Increased frequency of sexual health screening could reduce transmission of STIs, and this policy is advocated in Australia and America. UK guidelines are vague, advising increased screening for MSM with risk taking behaviours but without specifying frequency or behaviours. Aim: to assess what advice UK clinics give MSM about how frequently they should receive sexual health screening, and how this varies with risk taking behaviours.

**Methods** BCCG members representing UK level 3 sexual health clinics were asked to complete an online survey assessing how often they would advise MSM with different patterns of risk taking behaviours to attend for screening.

**Results** 53 clinics responded. 53% had local guidance on screening frequency, with 89% based on national guidelines. 94% BCCG members and 59% local guidelines identified behaviours requiring increased screening frequency. The majority (53–66%) advised 3 monthly screening for MSM with over 10 partners in the last 6 months, attending sex on premises venues, using recreational drugs during sex, using the Internet to find partners, participating in group sex, or being HIV positive and sexually active. 32% and 40% respectively recommended 6 monthly screening for sexually active MSM and for those who had unprotected anal sex in the last 12 months.

**Discussion** Whilst the majority of clinics surveyed would recommend 3–6 monthly screening for MSM with risk taking behaviours, this varies with many clinics providing no specific advice on screening frequency. Clear UK guidance is needed to respond to the HIV

epidemic in MSM by promoting early diagnosis of incident infection, and to ensure that efforts to contain costs through service contraction do not impinge on access or screening for this important group.

**P5.035 WITHDRAWN BY AUTHOR**

**P5.036 THE FIRST CLUSTER RANDOMISED TRIAL OF A MOLECULAR CHLAMYDIA AND GONORRHOEA POINT-OF-CARE ASSAY**

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**Introduction** In many settings, control of sexually transmissible infections (STIs) is compromised by lack of laboratory infrastructure, physical distance from laboratories and loss to follow up of patients. Point-of-care (POC) tests have the potential to provide timely diagnosis, treatment and partner notification, and in turn reduce infection rates. In April 2013, we will implement the first cluster randomised trial of chlamydia and gonorrhoea POC testing in remote Aboriginal communities where STIs are endemic.

**Methods** The study, called TTANGO (test, treat and go), will measure the effectiveness, cost-effectiveness and cultural and operational acceptability of POC testing for chlamydia and gonorrhoea infections. The study design is a crossover, cluster, randomised controlled trial involving 12 health services in remote Aboriginal communities in Australia. The primary outcome is the percentage of people with persistent chlamydia and gonorrhoea positive tests. The trial runs for 2 years and is a partnership between research, government and community organisations.

**Results** TTANGO is reaching the conclusion of the preparation phase and has achieved significant steps, including the engagement of remote health services and communities, a comprehensive laboratory and field evaluation to select the ideal assay, development of the first formal training package for chlamydia and gonorrhoea POC testing, and a quality assurance programme. The GeneXpert® CT/NG molecular POC assay was selected for the trial as it showed very high sensitivity and specificity compared to other assays, was easy to use and results were available in approximately 90 minutes. This paper will discuss progress in preparing and implementing TTANGO, the methodology and evaluation.

**Conclusion** The results of this RCT will provide crucial information to guide sexual health clinical practise in remote Aboriginal communities and other settings internationally. Mathematical modelling and health economic analyses will be used to make the case for large scale implementation of this technology.

**P5.037 EXPERIENCE OF RAPID HIV TESTING INCREASES ITS ACCEPTABILITY TO CLINICAL STAFF IN PUBLIC SEXUAL HEALTH CLINICS IN SYDNEY**

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