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PREDICTING STI RISK AMONG PEOPLE ATTENDING SEXUAL HEALTH SERVICES: DEVELOPMENT OF A TRIAGE TOOL TARGETING BEHAVIOURAL INTERVENTIONS AMONG YOUNG PEOPLE

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Background/introduction There are very limited resources for delivering sexual health promotion within sexual health services (SHS).

Aim(s)/objectives Santé, a feasibility study for a trial of sexual risk reduction interventions, is developing a triage tool embedded within the electronic patient record to target interventions by risk score among young people (16–25 years) attending SHS.

Methods We used GUMCADv2, the national mandatory STI surveillance dataset (2013–2014 – Model 1), and the GUMCADv3 pilot (July–October 2015 – Model 2). Predictive logistic regressions for acute STI diagnosis were run. Model 1 only considered demographic and clinical variables; Model 2 also included enhanced behavioural data (number of partners, new partners, and condom use in the past 3 months).

Results 936,251 and 619 patient-episodes were included in Models 1 and 2 respectively, of which 11% and 4% involved an STI diagnosis. In Model 1, predicted risk of STI diagnosis ranged between 1–47% (pseudo-R²: 1.9%). Referring the riskiest (highest decile) patients to more intensive interventions gives a sensitivity and specificity of 70% and 45%, respectively, and a positive predictive value (PPV) of 13% for STI diagnosis. In Model 2 the predicted risk of STI was 0–53% (pseudo-R²: 23%), and referring the riskiest patients demonstrated an improved sensitivity (76%), specificity (87%) and PPV (25%).

Discussion/conclusion Routinely collected surveillance data can be used to triage young people for targeted risk-reduction interventions, but this is more robust if behavioural data are taken into account. Addition of behavioural data to routine STI surveillance (GUMCADv3) is a powerful way to target sexual health promotion.

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THE NATIONAL HIV SELF-SAMPLING SERVICE

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Background/introduction In November 2015, Public Health England, with the support of Local Authorities, launched a nationwide HIV self-sampling service free for populations most at-risk of HIV acquisition (www.freetesting.hiv). In February 2016 the service was devolved to participating local authorities who have taken responsibility for the service in their areas.

Aim(s)/objectives To determine who is accessing the service and whether it reached most at-risk groups (including MSM and Black African communities) and first-time testers.

Methods Disaggregated anonymised data from service users ordering kits from 18 November 2015 – 31 January 2016 were analysed, including: ethnicity, gender, sexual orientation, local authority residency and self-reported HIV testing information.

Results During this period there were 17,114 kits ordered of which 51% (n = 8,706) were returned with a 1.4% reactive rate (n = 122). 82% (n = 7149) of kits returned were from MSM with a 1.34% reactive rate (n = 96). 32% reported never testing and 40% testing over a year ago. 18% (n = 1537) of kits returned were from heterosexuals. Of those 42% (n = 649) were from Black African individuals with a 1.54% reactive rate (n = 10) and 31% reported never testing and 45% testing over a year ago. Manchester, Leeds and Birmingham are the local authorities presenting the highest service demand across England.

Discussion/conclusion The national self-sampling service has been successful at engaging most at-risk populations for HIV acquisition across the nation and those who had not tested for HIV as frequently as recommended in national guidelines; including many who have never tested before.

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ROLE OF PRIMARY CARE IN THE DIAGNOSIS OF STIS IN ENGLAND

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Background Sexually transmitted infection (STI) diagnoses made in genitourinary medicine (GUM) clinics have been collected in England for many years, but little is known about the contribution of GPs to STI diagnoses.

Objectives To assess trends in diagnosis rates of selected STIs from GPs.

Methods Longitudinal analysis of age- and sex-standardised population diagnosis rates of selected STIs from GPs in England from 2005–2014 was performed using data from the Clinical Practice Research Datalink (CPRD).

Results The proportion STI diagnoses made by GPs varied by infection, ranging from 2% (gonorrhoea) to 34% (genital herpes), in 2014. From 2005–2014, diagnosis rates [95% CI] per 100,000 registered population decreased for chlamydia (51.4 [50.7–52.0] to 24.9 [24.5–25.3], p = 0.009), gonorrhoea (3.4 [3.2–3.5] to 1.8 [1.7–1.9], p = 0.02), genital warts (73.1 [72.4–73.9] to 38.4, [37.9–39.0], p = 0.004) and genital herpes (36.9 [36.4–37.4] to 26.1 [25.7–26.6], p = 0.02). Diagnosis rates for all four STIs were higher among women, particularly for chlamydia and genital herpes where respective 2014 rates were 38.3 [37.6–39.1] and 41.8 [41.0–42.5] compared to 11.1 [10.7–11.5] and 10.0 [9.7–10.4] in men.

Conclusion While the rates of STI diagnoses in GUM clinics in England have steadily risen in the past 10 years, particularly in men, diagnosis rates of these four STIs in GPs have decreased between 2005 and 2014. The high diagnosis rates seen in women in GPs, suggest that primary care has an important role in the diagnosis of STIs in women although their relative contribution may have declined in recent years.

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A PARTNER NOTIFICATION BUREAU IN ACTION: OUTCOMES FOR CENTRALISED MANAGEMENT OF POSITIVE GONORRHOEA AND CHLAMYDIA RESULTS FROM PRIMARY CARE BY A SEXUAL HEALTH SERVICE

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Background/introduction Centralised management of positive results by a 'Partner Notification Bureau' has been suggested by the National Chlamydia Screening Programme. From September 2014 positive results for chlamydia and gonorrhoea from primary care were reported directly to the sexual health service in a UK city for management.

Aim(s)/objectives To evaluate the effectiveness of centralised management of treatment and partner notification (PN) by assessing outcomes for the first year and to estimate impact on health adviser workload.

Methods Health adviser records were reviewed retrospectively to assess outcomes in terms of : patients informed of their result, confirmed treated at any service, and offered PN discussion; partners attended.

Results Gonorrhoea: between September 2014 and August 2015 there were 46 positives reported (31 female). Forty five were informed, confirmed treated, and had a PN discussion by phone. The number of partners reported or verified attended per case was 0.8 (37/46). Chlamydia: Between September 2014–August 2015, 457 positives were reported (352 female). Of these, 440 (96%) were informed and had PN discussion, and 448 (98%) were confirmed treated. The number of partners reported or verified attended per case was 0.98 (450/457). Outcomes for both exceeded the national PN standard of 0.6 partners attending per case. Partner notification workload increased by approximately 10%.

Conclusion Centralised management of gonorrhoea and chlamydia positives from primary care resulted in excellent treatment rates and PN outcomes. However, additional health adviser resources are required to manage the extra workload.

Section 2 Oral Case Presentations

CC1 "PERSISTENT GENITAL AROUSAL DISORDER – THE EXPERIENCE OF A LONDON TEACHING HOSPITAL"

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Background Persistent genital arousal disorder (PGAD) is a condition seen mainly in women characterised by spontaneous and often unrelenting sensation of genital arousal in the absence of sexual desire or stimulation. These sensations typically do not fully remit with orgasm and are by definition intrusive and distressing. The condition overlaps in some cases with pudendal neuralgia but needs to be differentiated from hypersexuality. Patients may present preferentially to GUM clinics in the knowledge that sexual symptoms will not be trivialised. Different opinions exist as to triggers, causes and treatment. Taking this into consideration we analysed a cohort of patients with PGAD assessing whether they were any common themes in terms of precipitating and relieving factors.

Aim To describe our clinical experience and ascertain number of patients with diagnosis, common themes and treatment modalities.

Methods 57 patients were diagnosed with PGAD since departmental code was introduced in 2006 and 39 patients notes were located and reviewed.

Results Of these 69% were in a relationship and 64% had no history of past sexual abuse. Relieving factors were also varied among the cohort including masturbation and distraction. 95% were referred for mindfulness cognitive behavioural therapy and

51% were on medication such as amitriptyline, gabapentin, venlafaxine and nortriptyline. 72% were referred for pelvic floor physiotherapy.

Discussion PGAD is rarely seen estimates say 1–6% are affected by this hence it is important as sexual health clinicians to be aware of it to reduce delays in diagnosis. Overall management of PGAD requires a holistic approach with multidisciplinary team involvement.

CC2 DOES MYCOPLASMA GENITALIUM CAUSE PROCTITIS? A CASE REPORT

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Background/introduction Mycoplasma genitalium is an emerging sexually transmitted pathogen implicated in urethritis in men and cervicitis and pelvic inflammatory disease in women. The overall prevalence of rectal mycoplasma genitalium was 4.4% in one study of MSM. However, symptomatic disease is not well reported.

Aims/objectives We describe a case of symptomatic rectal mycoplasma genitalium

Methods Retrospective case not review

Results A 19 year old MSM attended with a 2 week history of rectal bleeding, discharge and tenesmus. His last sexual contact was 6 weeks previously: condom-less receptive anal intercourse. On examination, he had no lymphadenopathy, no rash and no evidence of oral ulceration. On proctoscopy, he had erythematous mucosa and multiple small discrete rectal ulcers. Triple site swabs were taken including gonorrhoea culture, rectal swab for LGV and multiplex PCR (syphilis, HSV and mycoplasma genitalium). A full blood borne virus screen was performed. He was treated with ceftriaxone (500 g IM), azithromycin (1 g PO), doxycycline (100 mg PO BD for 7 days) and acyclovir (400 mg PO TDS for 5 days) but his symptoms did not resolve. All tests were negative except rectal multiplex PCR was positive for mycoplasma genitalium. He was diagnosed as having symptomatic mycoplasma genitalium infection and was treated with a prolonged course of azithromycin. His symptoms subsided.

Discussion/conclusion Mycoplasma genitalium has been found in the rectum of MSM and is usually asymptomatic. We describe a case of proctitis which seems to be related to Mycoplasma genitalium. MSM with unresolved proctitis should be tested for Mycoplasma genitalium.

CC3 LYMPHOGANULOMA VENEREUM PRESENTING AS A RECTAL TUMOUR

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Background/introduction Lymphogranuloma Venereum (LGV), due to an invasive serovar of Chlamydia Trachomatis, is endemic in the United Kingdom in men who have sex with men (MSM). It is associated with the human immunodeficiency virus (HIV) and other sexually transmitted infections including hepatitis C.

Aim(s)/objectives We present a case of LGV mimicking a rectal tumour in a heterosexual male.