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 LYMPHOGRANULOMA 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.