were tested for MG using the Fast-track Diagnostics™ urethritis PCR.
Results 461 patients were tested for MG. 30/461 (6.5%) were positive. Median age was 30 years(range 16–53) and more MG-positive males (26/30) than females (4/30) were identified. 1/4 females provided a cervical sample and 3/4 vaginal swabs. Of males, 1/26 provided a penile swab, 3/26 rectal swabs, and 22/26 (84.6%) gave urine samples. All females self-identified as heterosexual. 10/26 (38%) men self-identified as men who have sex with men (MSM); 6/30 (20%) patients were known to be HIV-positive, all of whom were male and 5/6 (83%) were MSM. 9/30 (30%) patients were treated with 1g single dose azithromycin and 5/30 (16.7%) received a regimen of azithromycin 500mg stat followed by 250mg od for 4 days. Tests of cure were done in 13/30 (43.3%). 4/13 (30.7%) remained positive and all received moxifloxacin, which was curative.
Conclusion We found MG in symptomatic patients attending our service. Many patients were treated with single dose azithromycin which may be insufficient to clear infection and lead to acquired resistance. Local protocols for persistent urethritis and PID should include routine testing for MG, and newer and better access to diagnostics are urgently needed to support this.

P013 WHEN IS A HERNIA NOT A HERNIA AND LYMPHOMA NOT LYMPHOMA?

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Background/introduction Lymphogranuloma vereneum (LGV) is a relatively common cause of proctitis and other gastrointestinal symptoms in men who have sex with men (MSM). Other symptoms and signs may present and unless a careful sexual history is taken STI may not be considered in the differential diagnosis.
Aim(s)/objectives To illustrate the potential for mis/inaccurate diagnosis of groin swellings in sexually active MSM and provide a case that can be used for teaching primary care, surgical, oncology and histopathology colleagues.
Methods We present a case of a 55 year old HIV-infected MSM who presented to surgical colleagues with left groin swelling.
Results The patient underwent open surgery to repair an inguinal hernia. At surgery he was found to have significant inguinal lymphadenopathy. Histopathological analysis at the regional pathology centre identified a B cell lymphoma and referral was made to a haematologist to start anti-cancer therapy. In the interim the patient attended our GUM service, was diagnosed with rectal LGV and treated with antibiotics. His lymphadenopathy resolved and staging CT was negative.
Discussion/conclusion Careful consideration of the differential diagnosis of inguinal swelling should be undertaken and STI excluded prior to general anaesthesia and operative procedures whenever possible. Had this patient not attended his GUM clinic he may have undergone potentially toxic chemotherapy to treat LGV infection. This case serves to illustrate the need for open communication between GUM and other medical colleagues.

P014 AN AUDIT OF PREVENTION OF MOTHER TO CHILD TRANSMISSION SERVICES WITHIN A ANTENATAL CARE FACILITY IN A RURAL HEALTH CLINIC IN SWAZILAND

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10.1136/sextrans-2016-052718.69

Background/introduction Swaziland is recorded to have the world's highest HIV prevalence amongst adults and pregnant women. To address this epidemic Swaziland's Ministry of Health (MOH) has adopted the WHO four pronged approach to reducing new HIV infections in women and children.
Aim(s)/objectives To audit whether prevention of mother to child transmission (PMTCT) services at a rural health clinic in Swaziland meets the 2010 MOH targets.
Methods Retrospective data was collected for all women accessing ANC services at the clinic from 1st Feb to 25th May 2015 analysis was performed using Microsoft Excel 2013
Results 29 women accessed ANC services in this time period, 11 (37.9%) were known HIV positive and a further 4 (22.2%) tested positive at presentation. The clinic achieved a HIV testing rate of 94.4% (target 100%) and a partner testing rate of 11.1% (target 50%). 93.3% (15) of HIV positive women received efficacious antiretroviral therapy (target 97%) and 93.3% (15) of exposed infants were initiated on appropriate prophylaxis (target 95%).
Discussion/conclusion This audit has identified areas where action is required for ANC services at the clinic to meet MOH targets. Early HIV diagnosis and partner testing must be prioritised to reduce new born infections. Access to necessary treatment should be improved by establishing links to antiretroviral clinics.

P015 BASHH MSM SIG CLINIC SURVEY; TESTING AND VACCINATION

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Background/introduction/Aim(s)/objectives Our aim was to investigate practice across the UK in aspects of the clinical care of MSM who are HIV negative or of unknown status where evidence is absent, or guidance varies.
Methods An online questionnaire was drafted by the MSM SIG, tested by BASHH CGC members, revised and distributed to BASHH, FSRH members and CSP audit sites for one month to 31st October 2015.
Results There were 149 complete responses. Only 40% of respondents had a written protocol or policy on recall for HIV/STI testing of which 23% had an automated system to recall patients for testing. 50% routinely test for HIV at syphilis follow up. 90% of respondents report using both NAAT and culture for GC in contacts of gonorrhoea and 20% use both in asymptomatic men. 33% test anatomical sites according to sexual contact history. Self-taken throat (rectal) swabs for GC/Ct NAAT were used never by 26% (3%) and routinely in 18% (22.5%). 100% routinely test MSM for Hepatitis B exposure and over 50% for Hepatitis C. 78% routinely check HepB sAb levels

following vaccination. 79% routinely recall men for Hepatitis B vaccination.

Discussion/conclusion There is evidence of variation in clinical practice between clinics in the UK, not all of which can be explained by variations in local epidemiology and some of which has significant cost implications. Results have generated debate in the MSM SIG on the rationale for local policies.

P016 BASHH MSM SIG CLINIC SURVEY; HOLISTIC AND INCLUSIVE CARE

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10.1136/sextrans-2016-052718.71

Background/introduction MSM experience a disproportionate burden of ill health in relation to sexual health, mental health and substance use.

Aim(s)/objectives Our aim was to investigate practice across the UK in aspects of the clinical care of MSM where evidence is absent, or guidance varies.

Methods An online questionnaire was distributed to BASHH, FSRH members and CSP audit sites for one month to 31st October 2015. Questions covered assessment of risk factors for STIs and HIV and other elements of holistic care.

Results There were 149 complete responses. A written policy on obtaining a history of alcohol or recreational drug use was reported by 62% and 66% of respondents respectively. 58% and 57% had a documented pathway for alcohol or drug use problems. 67% had dedicated services for behaviour change interventions, but only 20% had dedicated sexual dysfunction services. HPV vaccination and PrEP were provided in some form (including with charges, or by private prescription) by 13% of clinics, but 58% and 45% reported no local discussion yet on HPV vaccination or PrEP for MSM. Support for local CaSH & Youth services in providing care for MSM was given through a formal arrangement or MCN by 30% of respondents and informally by a further 47%.

Discussion/conclusion There is considerable variation in the breadth of clinical holistic care offered across the UK, suggesting missed opportunities to address the interrelated health inequalities experienced by MSM. GUM clinics may be under-utilised as a source of local expertise in the care of MSM.

P017 ARE WE MISSING OPPORTUNITIES? — A RETROSPECTIVE AUDIT ON LATE DIAGNOSIS OF HIV

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Introduction 24% of deaths among HIV-positive adults in the UK are due to late diagnosis of HIV. Many 'late presenters' have previously been seen by healthcare professionals and the diagnosis missed. The study city also has a significantly higher late diagnoses rate (61%) compared to the national rate (45%).

Aim To identify: newly- diagnosed HIV positive patients between 2010- 2012; rates of 'late' diagnosis; missed opportunities for testing.

Methods Reviewing the case-notes of all newly diagnosed HIV positive residents in the study city, with a CD4 count <350 cells/μl.

National Testing guidelines were used to define the indicators for testing. The primary outcome was 'late' diagnosis (CD4 count <350 cells/μl). The secondary outcome was 'missed opportunity'(failure to diagnose HIV within one month) in the presence of an indicator for testing.

Results From 180 new HIV-positive cases reviewed 85 met the case definition of 'late' diagnosis, 38 of which had been diagnosed prior to 2010. Meaning the true number of late diagnosis cases during the audit period was 47 (26%). 14.8% of cases had pre-existing HIV indicators, and 46% of cases had missed opportunities for early diagnosis.

Conclusions This audit demonstrates that the actual late-diagnosis rate is lower than that reported previously. There is a high rate of missed opportunities, which warrants increasing the awareness of clinicians and the general population for early detection of HIV, the responsibility for which rests with both clinicians and commissioners.

P018 EVOLVING CONTRACEPTIVE OPTIONS IN INDIGENOUS COMMUNITIES IN PANAMA

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Background Use of contraception in Panamanian indigenous groups is significantly lower than in the general population. Birth-rates in the Ng-be-Buglé group are the highest in the country. A large proportion of the Ng-be-Buglé live in isolated, rural communities with limited sanitation and education facilities and poor access to local health services. A non-governmental organisation (NGO) has been providing primary healthcare to these communities since 2011 and introduced the contraceptive injection in 2013.

Aims To assess the level and trends of contraceptive injection use and to identify associated challenges.

Methods An observational study of depot medroxyprogesterone acetate (DMPA) use in women attending the NGO clinics was carried out.

Results 143 women from 16 communities have used DMPA from the NGO; 46.9% started in the last 6 months. The most common reason for commencing is family completion. Average age at commencing is 27.6 years (range 12–46) and number of children is 4 (range 0–14). Since starting, 13.3% have discontinued use and 25.9% have missed their most recent dose. Missed doses are commonly due to clinic non-attendance. Influence from spouses and misconceptions regarding side-effects are key factors in discontinuation.

Discussion Ng-be-Buglé communities are experiencing unsustainable population growth. Contraceptive options available to these communities remain limited. Despite a recent surge in the uptake of DMPA from the NGO, major challenges regarding long-term use and compliance remain. Our ongoing work aims to broaden contraceptive options for these people and includes implementation of a pilot study introducing the contraceptive implant.