same six months in 2007 to 2014. The total number of cases identified in 2015 were 151.

Results

Abstract P055 Table 1

	2007	2008	2009	2011	2012	2013	2014	2015
TOC (%) (Had TOC%)				– (36)	91 (66)	84.6 (53)	91 (60)	91 (60)
C4 Treatment (%)	100	100	100	98.60	100	100	100	99.3
PN (%)	82	95	92	98.60	100	100	100	96.7
PIL (%)	32	64	81	61	50	66	27	74
1st line (%)	77	96	100	97	88	100	97	93.4

Discussion/conclusion To my knowledge, this is the longest continuous audit of the management of *N.gonorrhoea* in the UK. I have seen continuous improvements in the performance of all five domains. We introduced an electronic reminder to provide patients with an information leaflet at the end of 2014. This has shown a marked improved from 27% to 74%. We aim to achieve full BASHH compliance in 2016.

P056 INFLUENCE OF COUNTRY OF BIRTH ON RISK OF STI DIAGNOSIS AMONG BLACK CARIBBEANS IN ENGLAND IN 2014

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Background/introduction In England, people of Black Caribbean (BC) ethnicity are disproportionately affected by sexually transmitted infections (STIs), but it is unclear whether this is associated with their country of birth.

Aim(s)/objectives To examine differences in STI diagnoses among UK- and Caribbean-born BC people.

Methods Data on STI diagnoses in BC people attending genitourinary medicine (GUM) clinics and living in England were obtained from the GUM Clinic Activity Dataset (GUMCADv2). Associations between being UK- or Caribbean-born and diagnosis with an STI were derived using univariate and multivariable multilevel logistic regression models adjusted for age, gender/sexual-orientation, residence, and HIV status.

Results BC people made 231,719 attendances in 2014; 81.9% were UK-born. The median age (years) was 25 for UK-born and 34 for Caribbean-born people ($p \leq 0.001$). Chlamydia, non-specific genital infection and gonorrhoea were the most commonly diagnosed STIs among UK- (37.4%, 19.5% and 13.7%) and Caribbean-born attendees (32.1%, 25.2% and 13.1%). From the multilevel analysis, UK-born attendees were less likely to be diagnosed with chlamydia (aOR 0.87 [95%C.I. 0.81–0.94]) and trichomoniasis (0.83 [0.71–0.97]), and more likely to be diagnosed with genital warts (1.24 [1.07–1.45]) than Caribbean-born attendees. The adjusted odds of a gonorrhoea diagnosis did not vary by country of birth.

Discussion/conclusion STI rates among black Caribbeans attending GUM clinics in England are high and might be influenced by STI epidemiology in their country of birth. Studies on the effectiveness of interventions aimed at reducing the burden of STIs in all black Caribbeans are urgently needed.

P057 NEISSERIA GONORRHOEA (GC): PERSISTENCE OF DNA DETECTION AFTER SUCCESSFUL THERAPY AND CHANGING PATTERN OF ANTIBIOTIC SENSITIVITY, 2007–2015

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Background/introduction Nucleic acid amplification testing (NAAT) is widely used in GUM clinics to diagnose GC infection; its in-built high sensitivity may potentially detect DNA from non-viable organisms following successful treatment. The BASHH national guidelines stipulate that test-of-cure (TOC) with NAAT should take place 2 weeks post-treatment. The purpose of this study was to determine whether this is an adequate time interval to perform TOC. We also analysed the changing pattern of antibiotic sensitivity between 2007–2015.

Aim(s)/objectives All GC cases at our clinic between 1st January and 30th June in 2007–2015 were identified and assessed for antibiotic sensitivity and TOC.

Methods In 2015 there were 151 cases; culture and sensitivity results were available for 99 cases. TOC with NAAT was done in 81 cases. There were 10 cases where the NAAT was SDA positive but PCR negative. Overall a TOC with NAAT was performed between 7 and 50 days post-treatment with a mean, median and mode of 17, 14 and 14 days respectively.

Abstract P057 Table 1 Gonorrhoea 2007–2015

	2007	2009	2011	2012	2013	2014	2015
% fully sensitive	46	67	59	49	79	59	43
Resistance to 1 antibiotic group	27	15	20	38	10	20	23
Resistance to 2 antibiotic groups	15	10	16	8	6	13	21
Resistance to 3 antibiotic groups	12	2	5	3	2	8	5

Conclusion None of the cultures were resistant to ceftriaxone. However prevalence of multi-drug resistance in N.gonorrhoea has shown gradual decline from 27% in 2007 to 8% in 2013. The trend has reversed in 2014 with increasing multi-drug resistance to 26% in 2015. Since 2013 I have also looked at the persistence of DNA detection following successful therapy and this supports the BASHH Guidelines of TOC 2 weeks post treatment.

P058 TWO CASES OF DELIBERATE ANTIRETROVIRAL OVERDOSE: RALTEGRAVIR AND TENOFOVIR DISAPROXIL FUMARATE/EMTRICITABINE

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Background/introduction There is a high incidence of psychiatric illness amongst those living with HIV. This is associated with a risk of deliberate self harm including overdose with antiretrovirals. There are a small number of publications describing overdose with antiretrovirals but none describing overdose with raltegravir.

Aim(s)/objectives In this report we aim to describe two cases of overdose with antiretrovirals: the management, investigations and resultant complications.

Methods The patient case notes and laboratory test results were reviewed.

Results Case 1: A 28 year old HIV-positive man presented 96 hours after taking a deliberate overdose of 40 x 400mg raltegravir tablets. He developed mild symptoms of diarrhoea, abdominal cramps and a sore chest. Results post-overdose: electrolytes and renal function: normal; liver function tests: ALT 58, others normal; creatinine kinase 67; haematology: normal; therapeutic drug monitoring (TDM) results: raltegravir not detected 96 hours post overdose. There were no serious complications. Case 2: A 52 year old HIV-positive man presented 24 hours after taking a deliberate overdose of 18 × Truvada (tenofovir disaproxil fumarate/emtricitabine). He had no symptoms related to the overdose. Results post-overdose: urinalysis: normal; electrolytes and renal: phosphate 0.75, creatinine 94; TDM: 24 hours: 207 ng/ml; 48 hours: 80 ng/ml; 72 hours: 16 ng/ml; 192 hours: 2 ng/ml. There were no serious complications.
Discussion/conclusion The patients in our case series showed few side effects and no serious sequelae as a result of their overdose. There seems to be little guidance available to guide management of such cases.

P059 A REVIEW OF SEXUALLY ACQUIRED PROCTITIS: AN ARRAY OF SYMPTOMS, INVESTIGATIONS AND TREATMENTS

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Introduction With recent lymphogranuloma veneruem (LGV) and Shigella outbreaks amongst men-who-have-sex-with-men (MSM), proctitis has become a prominent clinical issue. There is no UK guideline regarding proctitis management but guidance is available from IUSTI and CDC.
Objectives To review our proctitis cases and generate a clinic policy to standardise practice.
Methods Casenotes coded C4NR between 01/01/14–31/12/15 were reviewed with data collated and analysed via Microsoft Excel.
Results 100 care episodes were reviewed (92 patients, 6 attended twice and 1 thrice). All patients were male; 83 homosexual, 8 bisexual and 1 heterosexual. 67 patients were White British, 31 were HIV positive. Median age was 29 years (range = 18–62). Presenting symptoms were varied with rectal pain (58), discharge (54), and bleeding (44) most common. Proctoscopy in 82 cases found varying signs (32 discharge, 24 oedema, 25 contact bleeding, 10 ulceration). Microscopy was diagnostic of proctitis in 39/84 (46.4%) patients. Physician-requested investigations were:

Abstract P059 Table 1 Sexually acquired proctitis

Test	Performed	Positive results
Chlamydia trachomatis TMA	100	14 (including 6 LGV)
Neisseria gonorrhoea TMA	100	28
Gonococcal culture	98	24
Herpes Simplex PCR	30	9
Treponema pallidum PCR	27	1
Treponemal serology	93	5
Stool culture	13	4

Treatment at initial visit was predominantly doxycycline-based (99/100), with course length varying from 7–21 days. Concurrent therapies were influenced by clinical findings and reported contacts; predominantly ceftriaxone (53), azithromycin (31), and aciclovir (19).
Conclusions Gonorrhoea incidence was high (28%), as was herpes when requested (30%). Updated clinic policy for all proctitis patients includes requesting Herpes Simplex PCR and presumptive treatment for gonorrhoea.

P060 ARE WE 'SPOTTING THE SIGNS?'

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Background/introduction In 2014, BASHH/Brook piloted a pro-forma for identifying risks of child sexual exploitation in sexual health settings in the light of cases of child sexual exploitation identified nationally. Use of the pro-forma was promoted. The form was introduced in our unit in October 2014 following discussion. This replaced the 'under-16's risk-assessment,' used previously.
Aim(s)/objectives To assess as to whether the pro-forma was being used overall, with in-depth analysis of key components of the document.
Methods Retrospective note audit between 01/04/15–30/09/215 conducted. 44 attendees under 18, identified (17 male, 27 female)
Results The form was used in 39/44 (88.6%). Assessment of Fraser competence was documented in 34/42 (81%); 2 attendees were over 16. There was documentation that 'confidentiality clause' was discussed in 37/44 (84.1%). Age of partner was documented in 35/42 (83.3%); 2 patients had never had sex and hence were excluded. Name of social worker was documented in 7/13 (53.8%) attendees who had indicated they had one. 31 attendees had no social worker. Professional analysis was completed in 16/44 (36.4%). However, a further 10 notes had comments documented, which increased completion rate to 59.09%.
Discussion/conclusion After initial concerns raised by Staff about time taken to complete the form and the qualitative nature of information included in the form, this was incorporated into most consultations including under-18 attendees. Documentation on most key aspects of the pro-forma was generally good, with room for improvement. A feed-back session for staff combined with a further dedicated teaching session on safe-guarding is organised to improve this.

P061 SAFETY OF SINGLE DOSE GENTAMICIN COMPARED WITH MULTIPLE DOSE REGIMENS

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Background Traditionally, gentamicin is given eight hourly, guided by drug levels. Several studies have shown that single-daily dosing of gentamicin offers an equal, if not improved, toxicity profile compared to traditional dosing. Single one-off dose gentamicin has been suggested as treatment for gonorrhoea, but its safety has not been reviewed.
Aim Systematically review the frequency and type of adverse events associated with a single dose of intravenous or