Abstract P070 Table 1 Frequency of chemsex consultations reported by English clinics split into urban/rural category (n = number of clinics):

Frequency of Chemsex Consultations	Group A clinics (urban conurbation) n(%)	Group B clinics (Urban + city/town) n(%)	Group C Clinics (Urban + rural) n(%)	Group D clinics (Non-urban) n(%)	Total n	P value
Never	7 (19%)	5 (12.5%)	3 (30%)	4 (27%)	19	
Monthly or less	16 (44%)	28 (70%)	5 (50%)	8 (53%)	57	
Weekly	10 (28%)	5 (12.5%)	2 (20%)	3 (20%)	20	
At least daily	3 (8%)	2 (5%)	0	0	5	
Total	36	40	10	15	101	0.851

Background/introduction Sexualised substance use (chemsex) amongst men who have sex with men is well documented in some areas (London, Brighton, Manchester), and associated with high-risk sexual practices and acquisition of sexually transmitted infections.
Aim(s)/objectives To explore demand for chemsex services in UK GUM clinics, including outside major conurbations
Methods An online survey was distributed to clinical staff in GUM clinics across the UK. Analysis at clinic level was undertaken for England, with clinics split into 4 categories: (A) urban conurbation, (B) urban with city/town, (C) urban with significant rural, and (D) non-urban.
Results 357 individuals responded from 152 clinics, 90% were from England. Country–specific clinic response rates were 63% (135/214) in England, 80% (4/5) Northern Ireland (NI), 8% (3/39) Scotland and 83% (10/12) Wales. 82% (227/278) of respondents reported seeing patients who disclosed chemsex (82% England (205/251), 83% NI (5/6), 75% Scotland (6/8), 85% Wales (11/13)), and there was broad consensus that chemsex services (86%) and training were needed (98%). 64% (68/106) of clinics reported routinely asking selected patients about chemsex, 10% (11/106) asked all patients, and the remainder did not ask. Although the proportion of clinics seeing chemsex and the frequency of chemsex consultations was reported to be higher in more urban settings, differences were not significant and many clinics in rural areas reported chemsex consultations (Table 1).
Discussion/conclusion Chemsex consultations occur in most GUM clinics across the UK albeit to varying degrees. These data suggest a widespread need for specialist chemsex services and training.

P071 COST EFFICACY SAVINGS ON SEROLOGICAL FOLLOW UP FOR SYPHILIS AT AN URBAN SEXUAL HEALTH CLINIC

Rebecca Gilson. *Chalmers Centre, Edinburgh, UK*

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Background/introduction General Practitioners (GPs) in Lothian are requesting syphilis serology in 65% of individuals being tested for HIV. Adding syphilis to the remaining 35% would cost around £7000. In Edinburgh full serology (IgG, RPR, TPPA, IgM) is performed in all with a previous syphilis diagnosis. HIV positive individuals are tested 6 monthly. BASHH 2015 Syphilis Guidelines recommend RPR follow up and annual monitoring in HIV positive individuals. The aim was to evaluate if full serological screening was appropriate and whether cost savings could be made.
Methods One hundred individuals with full serological testing for syphilis, 30/9/15 to 29/10/15. Age, risk group, HIV status, stage of infection, PCR, treatment, symptoms, follow up and infection risks were collated.
Results 88 male, 12 female. Twenty one early infection (all positive RPR), 4 re infection (all rise in RPR), 7 late latent and 54 treated infection. Forty seven HIV positive. Of these 14 (21%) had no ongoing risks and 16 (34%) had ongoing risks, longstanding RPR 0. Forty HIV negative. Twenty four (60%) were MSM with treated STS, and a longstanding RPR 0.
Recommendations Testing should be annual RPR in HIV positive individuals with no ongoing risks. In those with ongoing risks RPR alone sufficient for monitoring. All with re infection would have been picked up on RPR. In HIV negative individuals, most had ongoing risks but a longstanding RPR 0. Monitoring with RPR only would have diagnosed all re infections.
Discussion It was difficult to vary testing based on risk assessment and concerns that RPR only may miss prozone. However, there was agreement that IgM should no longer be performed. At £3.77/test approximately £377/month would be saved in this group alone. This would apply to all other testing with considerable cost savings

P072 EQUITY OF ACCESS TO ONLINE SEXUALLY TRANSMITTED INFECTION SELF-SAMPLING SERVICES IN LAMBETH AND SOUTHWARK: AN EARLY VIEW OF THE DATA

[1]Sharmani Barnard*, [2]Katy Turner, [2]Katherine Looker, [1]Ioannis Bakolis, [3]Caroline Free, [1]Paula Baraitser. *[1]King's College London, London, UK; [2]University of Bristol, Bristol, UK; [3]London School of Hygiene and Tropical Medicine, London, UK*

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Background In 2015, free access to online services for STI self-sampling was made available to residents in Lambeth and Southwark. Little is known about who accesses online services within these boroughs and whether access is equitable between demographic groups.

Aims To describe the demographic factors associated with use of online services for STI self-sampling.

Methods A cross-sectional analysis of routinely collected data from April to October 2015 for online and sexual health clinics in Lambeth and Southwark. We included residents who attended sexual health clinics or used online sexual health services for basic STI testing and were over the age of 16. Data were analysed by means of logistic regression.

Results A total of 9,496 basic STI testing services were delivered, 6,697 (70.52%) were delivered in clinics while 2,799 (29.48%) were delivered online. Descriptive data for service use by demographic group is available in Table 1. When compared to residents aged 16–20 years old, residents aged 21–24 (OR = 1.93, $p \leq 0.001$), and 25–30 (OR = 2.17, $p \leq 0.001$)