treatment for confirmed pharyngeal infection. In addition, data showed a lack of consensus to guidelines regarding choices of look back period for sexual contacts.
Discussion/conclusion Management of GC varies across Europe and is not always in line with current European guidelines. Although there are minor variations between guidelines, there are vast discrepancies amongst European clinicians regarding clinical practice. There is a need for on-going Europe wide education to ensure that patients are receiving safe evidence based care.

P142 CHALLENGES AND OPPORTUNITIES OF A 'LOOK BACK' EXERCISE ON CHILD TESTING

Racheol Sierra, Vasuki Selvadurai, Judith Zhou*. *Western Sussex Foundation NHS Trust, Worthing, UK*

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Background/introduction The consensus document 'Don't forget the children' 2009 recommends that all HIV units perform a 'look back' exercise to establish the HIV status of children whose HIV positive parents attend that service, as a standard of care.
Aim(s)/objectives To perform a 'look back' to identify children born to HIV positive females in our unit. Determine their HIV testing status and establish a robust pathway for testing and recording outcome.
Methods A retrospective notes review of all HIV positive women registered with the Sexual Health Clinic.
Results 76 women identified, 66 had 149 children. Ethnicity was predominantly African (38/76). 48/76 women acquired infection abroad. Children at risk of vertical HIV transmission recognised in 53/66 women. Child testing identified and documented in 29/53 women (65 children); 8 were HIV positive. 10/53 had children resident abroad (23 children). Parental discussions on-going in 6/53 women. A further 3/53 women declined testing. In 3/53 records were incomplete and 2/53 testing in progress.
Discussion/conclusion Challenges of retrospectively identifying children at risk of undiagnosed HIV highlighted particularly in parents that have not disclosed their status to children. We identified a reliance on verbally reported documentation as evidence of child testing, the challenges of testing older children and the need for robust reporting between paediatric and adult services. Clinicians should continue to ask about children abroad who subsequently join parents in the UK to avoid missed opportunities for testing.

P143 AN AUDIT OF THE MANAGEMENT OF CHLAMYDIA TRACHOMATIS

[1]Nadia Ahmed*, [2]Hana Hassan, [2]Joyce Amedee, [2]Rita Browne. *[1]Mortimer Market centre, London, UK; [2]Whittington Health, London, UK*

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Background/introduction Chlamydia trachomatis (CT) is the most commonly reported bacterial STI in the UK.
Aim(s)/objectives We aimed to evaluate our overall management of CT.
Methods All patients with a positive CT NAATs result over a 2month period (August–September 2014) were identified from our electronic patient records; clinical data was collated and analysed using an Excel spreadsheet
Results 180 patients were identified; 54% female, 72.6% aged <25 years, 41.6% of Black Afro-Caribbean/UK ethnicity. 96.6% were heterosexual. 97 infections were from LVS and 1 urine (females); males 82 urine and 2 rectal swabs. Both rectal swabs were negative for LGV. 39% (70/180) were symptomatic; 19 males and 24 females had microscopy performed. 25.5% (46/180) had co-infections. 69% (125/180) had an HIV test; all negative. All contactable patients (174/180) were treated for CT and any co-infections. Three patients were treated elsewhere, and three were uncontactable. The median time from result to treatment was 2 (IQ (0–6) weeks. 36% (65/180) attended for a test of cure. One patient tested positive for CT due to re-infection. 8 patients had HIV tests repeated at their follow up attendance, all negative.
Discussion/conclusion Our centre meets the BASHH 2015 standards. Areas for improvement are HIV testing and performing microscopy in all symptomatic men to enable earlier treatment. We now offer repeat testing at three months only to patients aged <25 years and all MSM via a recall text reminder. This will enable better use of clinic resources through targeting higher risk patients and detecting re-infections as well as treatment failure.

P144 STAFF ENGAGEMENT SURVEY PRE- AND 6-MONTHS POST INTRODUCTION OF ROUTINE DOMESTIC ABUSE ENQUIRY

Rachel Sacks*, Nora Ponnusamy, Alison Mears. *Imperial College Healthcare NHS Trust, London, UK*

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Background/introduction In July 2015, routine domestic abuse (DA) enquiry was introduced in a busy, walk-in, inner-London, genitourinary medicine (GUM) clinic. Guidelines, proforma and management pathway were devised. Tiered training was/is provided (basic level for all staff, in-depth for Sexual Health Information Protection team and DA champions). A separate audit demonstrated 91% of walk-in GUM patients were asked about DA, following routine enquiry introduction.
Aim(s)/objectives To assess staff engagement with routine DA enquiry.
Methods On-line survey disseminated to GUM healthcare professionals, two weeks prior to, and 6 months post-introduction of, routine DA enquiry.
Results 27 vs 20 staff completed the surveys. The majority were female [70 vs 90%]. Respondents were doctors [48.1% vs 42.1%], nurses [44.4% vs 57.9%] and healthcare assistants [7.4% vs 0%]. 3.7% vs 20% had worked in GUM < 1 year. 87.5% vs 89.5% had received training, 85.0% vs 100% of these respectively had rated this good-excellent. 4.8% vs 66.7% of respondents reported having managed patients disclosing DA at least once/week. 14.3% pre-introduction vs 0% post-introduction respondents had never managed a patient disclosing DA. Respondents reported feeling 'very confident' asking about DA [16.7% vs 63.2%] and managing disclosures [8.3% vs 26.3%]. 45.8% vs 63.2% thought 'Routine DA enquiry was a great idea…why hadn't we introduced earlier?' 8.3% pre-introduction respondents had some reservations vs 0% post-introduction.
Discussion/conclusion Staff engagement in routine DA enquiry was high from the outset and improved over 6 months. Levels

of experience and confidence in DA enquiry and disclosure management improved dramatically over this period.

P145 AUSTRALIAN MSM'S VIEWS AND KNOWLEDGE OF PHARYNGEAL GONORRHOEA, WILLINGNESS TO CHANGE CURRENT SEXUAL PRACTICES AND THE ACCEPTABILITY OF USING MOUTHWASH TO REDUCE THE RISK OF PHARYNGEAL GONORRHOEA: A QUALITATIVE STUDY

[1,2]sandra Walker*, [1,2]Clare Bellhouse, [1,2]Jade Bilardi, [1,2]Christopher Fairley, [1,2]Eric Chow. *[1]Melbourne Sexual Health Centre, melbourne, Australia; [2]Monash University, melbourne, Australia*

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Background/introduction The pharynx is the most common site of gonorrhoea among men who have sex with men (MSM) and may serve as a reservoir for infection, with saliva implicated in transmission possibly through oral sex, kissing, and rimming. Reducing sexual activities involving saliva may reduce pharyngeal gonorrhoea however strategies that target the oral cavity warrant investigation.
Aim(s)/objectives This study aimed to explore MSM's views and knowledge of pharyngeal gonorrhoea, their willingness to change saliva transmitting sexual practices and the acceptability of using mouthwash to reduce transmission.
Methods 30 MSM, recruited from a sexual health clinic in Melbourne, Australia, were interviewed face to face or by telephone.
Results Most men considered pharyngeal gonorrhoea non-serious and attributed transmission to saliva and oral ejaculate. Most men would not stop kissing (n = 25), oral sex (n = 26), or consider using condoms for oral sex (n = 25) to reduce their risk of gonorrhoea. Kissing and oral sex were common and considered enjoyable but regarded as low risk sexual activities. Men were more likely to consider stopping sexual activities they did not enjoy or practice often including rimming (n = 21) and using saliva as a lubricant for anal sex (n = 28). If proven effective, most men reported they would use a mouthwash to reduce or prevent their risk of pharyngeal gonorrhoea.
Discussion/conclusion MSM are unlikely to stop sexual practices they enjoy and consider low risk. The findings from this study highlight the need for further exploration of innovative strategies such as mouthwash to reduce their risk of pharyngeal gonorrhoea.

P146 DIAGNOSING GONORRHOEA – HOW DO DOCTORS AND NURSES COMPARE? AN AUDIT OF GONORRHOEA MANAGEMENT IN A LARGE PROVINCIAL NHS TRUST

[1]Harriet Eatwell*, [1]Qiang Lu, [2]Elizabeth Foley, [1,2]Rajul Patel. *[1]University of Southampton, Southampton, UK; [2]Solent NHS Trust, Southampton, UK*

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Background/introduction Although gonorrhoea rates are rising, incidence of urethral and cervical infection remain low in comparison to historic data. There is therefore concern that expertise in microscopic diagnosis of gonorrhoea may be falling. Additionally, in light of emerging resistance of gonorrhoea to extended-spectrum cephalosporins, multiple guidelines highlight the importance of taking cultures from NAAT positive sites prior to antibiotic treatment.
Aim(s)/objectives To evaluate the sensitivity of urethral microscopy performed by doctors/nurses and the frequency with which cultures are taken from all NAAT positive sites prior to treatment.
Methods A retrospective case note review of 100 patients with a gonorrhoea diagnosis and all gonorrhoea contacts in the same time period.
Results 16 men with genitourinary symptoms had positive urethral cultures on initial visit. 16/16 (100%) had positive microscopy. 32 men with genitourinary symptoms had a positive urethral/urine NAAT, of which 30 had microscopy. In 25/30 (83%), microscopy was positive. When performed by doctors, this was 7/8 (88%), and by nurses was 18/22 (82%)(p = 0.46). 64 patients with a positive NAAT were consulted by exclusively doctors or nurses before treatment. 11/15 (73%) of doctors' patients and 30/49 (61%) of nurses' patients had cultures taken from all NAAT positive sites before treatment (p = 0.12).
Discussion/conclusion Microscopy in men with genitourinary symptoms remains sensitive in comparison with culture. However, there may be a case for a new auditable standard comparing microscopy with NAATs. Doctors and nurses are inconsistent in taking cultures from all NAAT positive sites prior to treatment and training in both groups should be addressed.

P147 ADDING A DOMESTIC ABUSE ROUTINE PROMPT TO THE GUM PROFORMA: BUT ARE WE ASKING THE QUESTION?

Rachel Sacks*, Anthi Lavida, Alison Mears. *Imperial College Healthcare NHS Trust, London, UK*

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Background/introduction In July 2015, a routine domestic abuse (DA) prompt was introduced in a busy, walk-in, inner-London, genitourinary medicine (GUM) clinic. DA guidelines, proforma and management flowchart were devised. Tiered training was/is provided at a basic level for all staff and in-depth for Sexual Health Information Protection team (SHIP) and DA champions. Auditable outcomes: DA question asked where safe (Target 100%), (SAFE: quiet/confidential space, seen alone, no child > 18 months present, professional interpreter if necessary), Complete DA proforma if DA disclosed (100%), Patient information leaflet (PIL) given if DA > 3/12 ago/no on-going risk (100%), Offered SHIP referral for risk assessment if DA < 3/12 or on-going risk (100%), DA disclosures correctly coded (100%).
Aim(s)/objectives Audit whether DA routine prompt asked, proforma completed, initial management pathway followed and disclosures coded.
Methods Data collected (notes review) on 100 consecutive, new, walk-in, GUM patients > 18 years-old, from 1st October 2015.
Results 59 female, 41 male. 91% patients asked about DA. 9 not asked: 5/41 (12.1%) male, 4/59 (6.8%) female. 9/9: no reason documented explaining omission. 5/91 (5%) disclosed DA (all female). DA proforma completed in 3/5 (60%) (1 patient declined further discussion). 1/4 (25%) had current/on-going risk and referred to SHIP. 3/4 DA occurred > 3/12 ago/no on-going risk: 1 accepted, 1 declined, 1 not offered PIL. 2/5 (40%) DA disclosures coded correctly (using in-house code).
Discussion/conclusion High enquiry rate (male patients less likely to be asked). DA protocol/flow chart followed in the