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*

10.1136/sextrans-2016-052718.199

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*

10.1136/sextrans-2016-052718.200

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*

10.1136/sextrans-2016-052718.201

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

majority of cases (proforma completion and referral to SHIP). There were low levels of accurate coding.

P148 AN AUDIT ON MANAGEMENT OF AFTERCARE FOR VICTIMS OF SEXUAL ASSAULT ATTENDING A DEDICATED AFTERCARE CLINIC

Vinod Kumar, Sashi Acharya, Joseph Arumainayagam*. *Walsall Healthcare NHS Trust, Walsall/West Midlands, UK*

10.1136/sextrans-2016-052718.202

Background/introduction A dedicated sexual assault aftercare clinic was set up at the integrated sexual health service to provide care for the victims of sexual assault. British Association for Sexual Health and HIV (BASHH) guidelines provide auditable measures to compare standard of care provided by services. We wanted to assess and improve the service offered to victims by the dedicated clinic.
Aim(s)/objectives To evaluate current clinical practice in the management of victims of sexual assault against the auditable outcome measures in the guidelines and improve the quality of care provided by communicating the findings, recommendations and action plans to team members.
Methods Retrospective review of all victims who attended the clinic between January 2015 and 31st September 2015 was performed. Cases were identified from coding used in the clinic. A standard data collection sheet developed on the basis of the BASHH guidelines was used.
Results Of the 53 victims identified, 96% were women, 83% were white, 13% were alcohol/drug related and 25% were under 18 years of age. 57% were referred by the sexual assault referral centre.96% reported one assailant and 55% were known to the victim. 100% had HIV risk assessment and were offered PEPSE if indicated. 98% were offered forensic examination if applicable, 93% emergency contraception if needed. Offer of prophylaxis against sexually transmitted infections: chlamydia 74%, gonorrhoea 62%, Trichomonas 49%. Offer of baseline testing for chlamydia 98%, gonorrhoea 100%, trichomonas 64%, syphilis HIV and hepatitis B & C 100%. Documentation of a plan for repeat STI testing 93%, documentation of offer of vaccination against hepatitis B 94% and assessment of child protection needs if under 18 years 77%.
Discussion/conclusion Areas to improve: documentation of a self-harm risk assessment, offer of emergency contraception, recording of a discussion of need for pregnancy test in 3 weeks after emergency contraception, documentation of offer of prophylactic treatment for chlamydia, gonorrhoea and trichomonas and documentation of an assessment of child protection needs if the victim was under 18 years of age. This will be re-audited in 6 months.

P149 PATTERNS OF SEXUAL BEHAVIOUR AMONG TRANSGENDER INDIVIDUALS IN MELBOURNE, AUSTRALIA 2011–2014

[1,2]Clare Bellhouse, [1,2]Sandra Walker*, [1,2]Christopher Fairley, [1,2]Lenka Vodstrcil, [2]Catriona Bradshaw, [1,2]Marcus Chen, [1,2]Eric Chow. *[1]Melbourne Sexual Health Centre, Melbourne, Australia*; *[2]Monash University, Melbourne, Australia*

10.1136/sextrans-2016-052718.203

Background/introduction Literature on the healthcare needs of transgender individuals is limited in Australia.
Aim(s)/objectives The aim of this study was to investigate the demographic characteristics, risk behaviours and STI/HIV positivity among male-to-female (MTF) and female-to-male (FTM) transgender individuals attending a sexual health clinic in Melbourne, Australia, between 2011 and 2014.
Methods A retrospective cohort analysis among 133 transgender individuals was conducted based on the first visit of the study period. Demographic characteristics, sexual behaviours, and HIV/STI positivity were examined.
Results 77 MTF, 28 FTM, and 28 unreported transgender status, attended 558 consultations with a median of two [IQR 1–5] visits. 70% percent attended for their first ever visit. Reassignment hormone use was 63% and surgery 27%. 11% had a history of injecting drug use, 74% were single/never married. In the last 12 months, 21% had sex overseas and 11% attended for counselling. Low median male sexual partners 1 [IQR 1–5] and female sexual partners 2 [1–4] were reported. MTF were more likely to be overseas born, older and work currently as a sex worker than FTM. STI positivity was 7% (n = 8) chlamydia; 5% (n = 6) gonorrhoea and 5% (n = 6) syphilis and HIV 3% (n = 1). There were no differences in positivity between MTF and FTM.
Discussion/conclusion In the Australian context STIs, HIV and sexual risk behaviours may differ to other developing and first world countries and therefore the healthcare needs may differ. Attention to differences in MTF and FTM transgender persons must be considered in health care.

P152 RECOGNITION OF LGV LYMPHADENITIS IN MSM

[1]Olamide Dosekun*, [2]Rebecca Simons, [2]Helen Iveson, [2]Katie Conway, [2]John White. *[1]Imperial College Healthcare NHS Trust, London, UK*; *[2]Guy's and St. Thomas' NHS Foundation Trust, London, UK*

10.1136/sextrans-2016-052718.204

Background There is a sustained high rate of lymphogranuloma venereum (LGV) amongst men who have sex with men (MSM) in the UK, with the highest annual number of diagnoses reported in 2015, yet prompt diagnosis of LGV, particularly from non-rectal sites, eludes clinicians.
Aims We present 4 cases highlighting the ongoing challenge of recognition of LGV lymphadenitis, particularly outside GUM settings, and challenges with diagnosis and management.
Case reports 4 MSM (3 with well-controlled HIV on antiretroviral therapy, 1 HIV negative) presented to their GPs with unilateral groin swellings, and were referred to haematology or surgical teams for investigation. Investigations included ultrasound, CT/MRI of the groin as well as fine needle aspiration, and in 2 cases surgical exploration followed by node excision. None of the patients had symptomatic proctitis, and triple-site NAAT swabs for *Chlamydia trachomatis* (CT) were negative, although 1 patient had previously diagnosed but untreated urethral CT one month prior. In 1 case, CT serology (WIF) showed a high L2 titre of >1:4000. In all cases, a 21-day course of doxycycline was commenced between 10–45 days from initial presentation. There was slow resolution of the lymphadenitis in 2 patients, necessitating a prolonged course of doxycycline (5 weeks), and addition of 7days of azithromycin 500mg once daily, respectively.
Conclusion Early recognition and management, including prompt aspiration/drainage of buboes and appropriate antibiotic treatment are key to management of LGV lymphadenitis. Poor