Results 129 episodes of infection were seen in 114 women. Age range 18–56; 76% (87/114) were ≤30 yrs. 103/114 (90%) were born outside of the UK; 77/103 (75%) were from Eastern Europe. 83/129 (64%) were vaginal infections (CT, GC or both); 40/120 (31%) pharyngeal and 26/129 (20%) rectal. 21/114 (18%) reported unprotected vaginal sex (UPVI) with clients. Where recorded 71/93 (76%) had a partner outside of work; of these 77% reported UPVI. 86/114 (75%) were HIV negative; 16% had never tested. 58/114 (51%) were deemed to have at least one vulnerability.

Abstract P201 Table 1

	2012	2013	2014
Total number FSW seen	560	538	517
*Number of CT infections	16	28	47
*Number of GC infections	8	18	22
Prevalence CT (%)	2.8	5.2	9.1
Prevalence GC (%)	1.4	3.3	4.2

*10 patients had both CT and GC

Discussion/conclusion Prevalence of both CT and GC is high and increasing in FSW, highlighting the importance outreach and testing in this vulnerable patient group.

P202 THE ACCEPTABILITY OF SELF-SAMPLING AT HOME FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN; RESULTS FROM THE FEASIBILITY STUDY TO DETERMINE THE TIME TAKEN FOR NAATS TESTS TO BECOME NEGATIVE FOLLOWING TREATMENT FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN

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Background/introduction Self-sampling with nucleic acid amplification tests(NAATs) for detection of chlamydia(CT) and gonorrhoea(NG) is increasingly being used in clinics, with much success. There is some data to suggest that it is acceptable to patients.
Aim(s)/objectives To assess symptoms, sexual behaviour and the acceptability of self-taken swabs for CT and NG, among participants in the 'Time to test of cure study for CT and NG'.
Methods Individuals who had a positive NAAT test for CT and/or NG were eligible. Self-taken specimens from the site of infection were collected at home. Data about sexual behaviour, symptoms and acceptability of home testing with self-taken samples was collected from questionnaires.
Results 102 men (87 MSM) and 52 women were recruited to the study, 84 had NG infection and 71 had CT infection. The median age was 28 years. Unprotected sexual intercourse in the last month was reported by 68% of MSM, 56% of heterosexual men and 51% of women. Symptoms were reported by 25% of MSMs, 50% of heterosexual men and 51% of women. 86% of participants found the information clear and easily understandable. 85% felt confident taking their own samples. 58% found the samples easy to take, 75% were happy to take their own swabs and 78% were happy to take samples at home.
Discussion/conclusion This data highlights the need for screening of asymptomatic patients and provides data to support that self-taken sampling is acceptable to patients. It also provides evidence to support home testing for CT and NG. Therefore allowing for greater access to testing and treatment and reducing the burden of infection in the community.

P203 HIV-TESTING AFRICAN SERVICE USERS WITHIN A NEWLY INTEGRATED SEXUAL HEALTH SERVICE - OUR EXPERIENCE

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Background/introduction HIV testing is recommended for all sexual health clinic attendees, and in generic health services for high risk groups including BME communities, especially in areas of high HIV prevalence such as Leeds (2.51/1000).
Aim(s)/objectives In July 2015 an integrated contraception and STI service, Leeds Sexual Health, began following commissioning by Leeds local Authority wherein the routine offer of HIV testing was extended to all attending service sites across the city, 4 out of 5 of which had previously seen patients for contraception and sexual health (CASH) services only.
Methods We prospectively examined data in those of African ethnicity regarding offer and uptake of HIV testing in these new settings.
Results Interim data indicates a much higher number of African patients accessing the integrated service but with a lower overall uptake of HIV testing, a significant disparity in HIV testing uptake between men and women, with significant numbers of patients choosing not to disclose their known HIV status at a community setting where they are accustomed to only sharing contraception information.
Discussion/conclusion Staff used to achieving HIV testing rates of over 80% in a GUM clinic setting have found patients reluctant to test when they have come expecting the previous service. We are therefore trying to assess genuine missed opportunities for testing and considering reframing HIV testing as a positive and routine intervention e.g. along with postpartum contraception, when trying to embed HIV testing as part of a standard, integrated sexual health care offer.

P204 IDENTIFYING PROBLEM DRUG USE IN MSM ATTENDING A DEDICATED SEXUAL HEALTH CLINIC

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Background/introduction There has been increasing recognition of the sexualised use of drugs (Chemsex) by MSM in recent years. Associations with sexual risk behaviour, HIV and other STIs are well described.
Aim(s)/objectives Our objective was to evaluate self-reported problem drug use in MSM attending a dedicated clinic.
Methods Patients attending the dedicated MSM clinic were given a simple questionnaire at registration, asking about: I) recent

drug use; ii) negative effects in general; iii) problems with drugs and sex. Patients were offered the opportunity to see a drug worker in the clinic, who collected more information about drugs used. Questionnaires completed between July 2014 and August 2015 were analysed.
Results 335 questionnaires were completed, but 59 excluded because of lack of patient identifiers. 170 of 276 (62%) reported recreational drug use. Of these 170, 38 (22%) reported negative effects in general, 31 (18%) reported problems with drugs and sex. However, these two groups were not identical and 14 reporting problems with sex answered "no" to the question about general problems. Excluding alcohol, 66 had drug details recorded: 16 had not reported problem use. Drugs associated with Chemsex such as GBL, Mephedrone, Ketamine and Crystal Methamphetamine were frequently identified.
Discussion/conclusions A simple questionnaire can identify problem drug use in a substantial proportion of MSM attending sexual health services. Asking specifically about problems relating to sex as well as general negative effects appears to offer a complementary approach. However, not all MSM who use "chems" will self-identify as having problem use, requiring vigilance on the part of clinicians.

P205 MANAGEMENT OF STI OUTBREAKS. WHAT CAN WE LEARN FROM EACH OTHER? A QUALITATIVE STUDY IN THE UK

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Background/introduction When outbreaks of sexually transmitted infections (STIs) are identified, effective management in a timely manner is essential for bringing the outbreak under control. Challenges to achieving this may vary, needing different approaches.
Aim(s)/objectives To review the management of outbreaks contrasting by setting and sexual orientation in order to inform responsive guidance.
Methods We interviewed clinicians and public health professionals who had recently been involved in identifying and managing STI outbreaks in the United Kingdom. Transcripts were analysed using thematic analysis.
Results Ten outbreaks were reviewed. The combination of public health teams' wider outbreak expertise and clinic staff's knowledge of the local population was essential when developing management strategies. Partner notification, mainly by health advisers, was very achievable in smaller heterosexual outbreaks but proved challenging in MSM focussed outbreaks where use of mobile apps or anonymous sex was common. Publicity campaigns via social media platforms and third sector organisations were employed although quantifying their impact was difficult. Education of local physicians resulted in syphilis referrals to sexual health services via ophthalmology, gastroenterology, oral and maxillofacial surgery and general practice. Enhanced surveillance enabled venue identification but was time consuming for clinic staff. In gonorrhoea outbreaks, the use of dual NAAT testing as part of the chlamydia screening programme enabled case finding.
Discussion/conclusion Traditional management strategies remain important but as the use of social media increases, novel strategies for managing outbreaks are needed. Education of other professionals is essential to maximise case finding.

P206 'DOCTOR, I THINK I'M ALLERGIC TO PENICILLIN' - PRIMARY SYPHILIS IN THE THIRD TRIMESTER

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Case Report We present a case of primary syphilis in the third trimester of pregnancy requiring penicillin desensitisation. A 34-year old woman was contacted by provider referral as a syphilis contact. She was 30 weeks pregnant. Both HIV and syphilis serology were negative at booking. She had presented to a community clinic with a sore vulva one week before and had empirical aciclovir for possible genital herpes. In our clinic, examination showed a small, non-indurated ulcer. Dark-ground microscopy was not done. A syphilis antibody screen was requested and reported positive six days later. On recall, repeat examination showed a larger, indurated ulcer. Treatment for primary syphilis was advised before confirmatory testing. However, the patient reported a possible reaction to penicillin. This was also documented by her general practitioner but the reaction was unknown. The next day she was admitted for penicillin desensitisation and the first dose of benzathine penicillin. Urgent referral to foetal medicine was made. Treponema pallidum was later detected by PCR on a vulval swab. Syphilis serology was reported as RPR 1:8 and TPPA 1:80. HIV serology and HSV PCR were negative. A second dose of benzathine penicillin was administered a week later, followed by 45 minutes of observation. After delivery at term, the neonate received 10 days of benzyl penicillin.
Discussion Learning points: 1. Exclude syphilis in anyone with genital ulceration, particularly in pregnancy. 2. Consult Immunology for advice on desensitisation regimen. 3. Write a syphilis birth plan as recommended by new BASHH guidelines

P207 CHLAMYDIA AND OUR 'BEST FRIENDS FOREVER' POLICY

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Background/introduction Our chlamydia screening target was challenging.
Aim(s)/Objectives To test more under 25 year olds in our area. To assess the number of new positives from the intervention and the potential impact on our target.
Methods We implemented a policy that all <25 yo's were offered kits for their friends. We developed kits with a 'site code' BFF (Best Friend Forever) enabling laboratory tracking. We developed a local code to determine if the offer was made and accepted/declined.
Results From Dec to Feb 2016 we saw 3072 <25 yo patients. We recorded that we offered BFF kits to 32% (989). They were accepted by 28% (277) who took 415 kits (average 1.5 kits each). Of these 15% (62) were returned and the chlamydia positivity in these kits was 11.2% (7). From these 7 positives via contact tracing 5 additional positives were identified. On average there are 0.6 chlamydia positives/case identified. If we extrapolate this we expect 6 additional chlamydia positives. From our intervention 7 cases, 5 chlamydia positive partners and an