knowledge of STIs was stated tentatively and 4) current STI knowledge did not necessarily facilitate health-seeking behaviour.
Discussion Engagement with STI-related knowledge among middle-aged adults is influenced by socio-cultural factors including the enduring stigmatisation of STIs. Interventions tackling stigma should aim to recognise and legitimate changing sexual partnerships across the life course.

O27 BEYOND SEXUAL HEALTH: IDENTIFYING HEALTHCARE NEEDS OF TRANS AND GENDER VARIANT PEOPLE IN A SPECIALIST CLINIC SERVICE

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Introduction Sexual health services targeted towards specific populations have been an effective way of responding to complex needs. As demand for gender identity services increases, a trend in hormone self-medicating has become more apparent with patients obtaining treatment from internet pharmacies, friends or illicit sources. This study highlights the healthcare needs of patients attending a clinic service for transgender patients.
Methods Clinical audit of a sexual health service for transgender people in 2015 and 2016.
Results 81 attendances were recorded (56 unique patients). Median age was 32 (IQR 24–41). Reported gender identity: Trans male (Assigned Female At Birth [AFAB]) 29 (51.8%), Trans female (Assigned Male at Birth [AMAB]) 15 (26.8%), Non-Binary (AFAB) 9 (16.1%), Non-Binary (AMAB) 3 (5.4%). AMAB patients were older than AFAB – Median age 39 vs. 29 years ($p=0.03$). Most attendances were for STI screening or genital health issues – 47 (58%). 6 (7.4%) attended for psychosexual assessment. 31 (38.3%) attended for endocrine advice and monitoring of hormone therapy. 13 (38.3%) patients were self-medicating (10 Trans male/Non-Binary AFAB, 3 Trans female/Non-Binary AMAB). 7 of the trans male and 1 of the trans female patients were using intramuscular hormones. Only 2 of the patients self-medicating had informed another healthcare professional.
Discussion The number of patients self-medicating without medical supervision raises concerns about adverse effects and unsafe injecting practice. Identifying such patients and meeting their needs raises novel issues for sexual health services. The study highlights the need for additional education for clinicians working with transgender patients.

O28 EXPERIENCE OF FEMALE GENITAL MUTILATION (FGM) IN A SEXUAL HEALTH CLINIC

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Introduction After recommendations from the Intercollegiate Guidelines in 2013, our sexual health clinic introduced a diagnostic code and mandatory proforma to identify, record and report FGM.
Methods Retrospective case note review of all patients coded FGM.
Results All patients presenting were over 18. There were 210 FGM patients; 30/210 Type 1 (clitoridectomy); 40/210 Type 2 (excision); 35/210 Type 3 (infibulation); 79/210 Type 4; 26/210 unclassified. 71 had consensual FGM as adults; of whom 69 were Type 4 (typically genital piercing), 2 were Type 1.

In FGM performed under 18 years old (139); average age of cutting was 6 years. Countries involved; Somalia 67% (93/139), Sierra Leone 7% (9/139), Eritrea, Nigeria and Ethiopia 4% (6/139) respectively. 14% (19/139) reported complications.12% (17/139) had prior reversal. 4% (6/139) expressed interest in reversal. 98% (136/139) knew FGM is illegal in the UK.

Abstract O28 Table 1 Associations if FGM performed under 18 years old or over 18 years old.

Association	FGM types 1–4 <18yrs	FGM type 1–4 >18yrs	P value
Pelvic pain/PID	**17%** (23/139)	**6%** (4/71)	**0.0289**
HIV/Hepatitis B/C	**11%** (15/139)	**3%** (2/71)	**0.0596**

There was no significant difference in the rates of bacterial STI's between both groups.
Discussion Our proforma assists in identifying and accurately recording information regarding FGM. No women required referral to police or social services. Some were signposted for surgical intervention. An increased incidence of pelvic pain was noted in those whose FGM was performed as children, with no reflected increase in bacterial STI's. An increased prevalence of blood borne viruses was also noted. Most women reported negative attitudes to FGM. Sexual health clinics are well placed to assist in awareness, risk assessment and education surrounding FGM.

O29 PATIENT EXPERIENCES OF SEX EDUCATION IN SCHOOLS – BRIDGING THE GAP

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10.1136/sextrans-2017-053232.29

Introduction Rates of STIs are increasing in the UK among young people: here is little data on the quality, coverage and outcome of sex education in schools.
Methods A Self-completed service-evaluation survey of patient experiences of sex education and subsequent sexual health was offered to all patients aged under 25 attending our GP level 2 sexual health service in November 2016.
Results 110 completed surveys were returned; Median age was 20. 64% F, 35% M, 1% Trans*. 23% identified as LGBT. 27/110(24.5%) reported previous diagnosis with an STI. 92/110 (83%) were educated in the UK; 10/110(9%) reported no sex education at all. 55% of respondents felt that the majority of their sex education came via school. The most covered topics in school sex education were: Puberty (81%), Contraception (80%) and STI's (80%). LGBT relationships (8%) and Anal sex (9%) were rarely included. Safe internet use was discussed with 18% of respondents, and consent with 39%. 63% felt they had enough information to protect themselves. 38%

Females and 33% MSM reported having sex without consent, conversely only 8% Heterosexual men reported non-consensual sex. 51% respondents would use a sexual health clinic to gain more information about sex, 55% would use a website for information.

Discussion Sexual health services may be ideally placed to work alongside schools in providing sex education. It must not be assumed when seeing patients that they are fully aware of how to protect themselves from sexual harm, and steps must be taken to address any gaps in knowledge attendees may have.

O30 TREATMENT FAILURE IN MYCOPLASMA GENITALIUM AMONG GUM CLINIC ATTENDEES

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10.1136/sextrans-2017-053232.30

Introduction Macrolide resistance in *Mycoplasma genitalium* (MG) is of growing concern in countries where azithromycin is used to treat non-gonococcal urethritis(NGU) but UK data is lacking. Patients with NGU or pelvic inflammatory disease (PID) are routinely tested for MG at our clinic and offered test of cure (TOC) 4 weeks post-treatment. We aim to determine rates of MG-positivity 4 weeks after treatment and their associations.

Methods Notes of MG-positive cases between December 2015 and November 2016 were reviewed and data collected on management.

Results 114 cases of MG were identified. 91(80%) were symptomatic and 12(11%) were MG contacts. Should be 52/339 (15%) men with NGU and 15/160(9.4%) women with PID were MG-positive.

80/114(78%) were given an azithromycin regimen first line. 59/114(53%) returned for TOC and 24/59(40%) were positive (23 following azithromycin; 1 following moxifloxacin). 19 returned for a second TOC and 14 were negative (1 following azithromycin and 13 following moxifloxacin second line). 5/19(26%) were positive (3 following azithromycin and 2 following moxifloxacin second line). One male patient with confirmed resistance to macrolide and quinolone therapy achieved microbiological cure with pristinamycin.

Having a positive TOC was significantly associated with risk of reinfection ($p=0.01$) and being symptomatic at TOC ($p<0.001$), but not significantly associated with gender, sexual orientation, HIV status, concurrent STI ($p=0.053$) and azithromycin use.

Discussion MG-positivity rates at 4 week TOC are high raising concerns of treatment failure although re-infection may also contribute. As commercial assays are imminently available, diagnoses of MG will increase and where possible should be accompanied by antimicrobial resistance testing.

O31 EXPLAINING ETHNIC VARIATIONS IN STI DIAGNOSIS: RESULTS FROM BRITAIN'S THIRD NATIONAL SURVEY OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL-3)

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10.1136/sextrans-2017-053232.31

Introduction In Britain, ethnic inequalities in STIs diagnoses persist. We hypothesised that these inequalities are associated with variations in sexual behaviour, which are influenced by differences in socioeconomic deprivation (SED) and mediated by substance use.

Methods Data from 14,563 participants of Britain's third National Survey of Sexual Attitudes and Lifestyles, a probability sample survey (N=15,162), were analysed by gender and ethnicity: white British (WB, reference category), black Caribbean (BC), black African (BA), Indian, Pakistani, white other (WO), and mixed ethnicity (ME). Using multivariable regression we examined ethnic variations in reported STI diagnoses adjusted for age, partner numbers (last 5y), recreational drug use (last 1y), and SED, and calculated adjusted odds ratios (AOR).

Results SED was higher in BC, BA, and Pakistani participants than other ethnicities (50% vs. 16%-38%, $p<0.0001$). compared with men from other ethnicities, BC and BA men reported higher partner numbers ($p<0.0001$), and concurrent partnerships (27% and 39% respectively vs. 4%–15%, $p=0.001$). compared with women from other ethnicities, ME women reported higher partner numbers ($p<0.0001$) and concurrency (14% vs. 2%–8%, $p=0.0005$). Recreational drug use was highest among WO and ME participants (26% vs. 4%-15% among other ethnicities; $p<0.0001$). Reported STI diagnosis was highest among BC men (8.7) and ME women (6.7%), and remained AOR high after adjustment for BC men (2.68, 95%CI: 1.13–6.34) and ME women (2.03, 95%CI: 1.11–3.68).

Discussion Ethnic variations in sexual behaviours, mediators, and SED partially explain higher STI diagnoses among BC men and ME women highlighting need for holistic interventions addressing these broader determinants.

O32 ETHNICITY AND SEXUAL BEHAVIOURS – THE ASSOCIATION BETWEEN ETHNICITY AND SEXUAL RISK BEHAVIOURS REPORTED BY HETEROSEXUAL MEN AND WOMEN IN A GUM SETTING

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