

Abstract P007 Table 1 Point of care test results

| Testing protocols | Correct diagnoses (%) | 95% Confidence Interval (%) |
|--------------------------|-----------------------|-----------------------------|
| SCP | 75.31 | 64.92 to 83.41 |
| P1: CT/NG/MG/TV | 100.00 | 96.96 to 98.30 |
| P2: CT/NG + MG reflex | 92.59 | 86.89 to 98.30 |
| P3: NG/MG | 88.89 | 82.04 to 95.73 |
| P4: CT/MG + NG reflex | 95.06 | 90.34 to 99.78 |
| P5: NG/MG + CT/TV reflex | 95.06 | 90.34 to 99.78 |

Discussion P1 was more effective than the SCP and all other protocols, however, may not be technically feasible. P5 was not statistically different from P1 and may be a valid alternative. Due to high rates of MG and CT infection in this cohort, a protocol including tests for both pathogens would be desirable for this population.

P008 A YEAR OF PROCTITIS: AETIOLOGY AND MANAGEMENT IN AN URBAN GUM CLINIC

¹Luke Hanna*, ¹Anton Brusov, ¹Sarah Stockwell, ^{1,2}Suneeta Soni, ^{1,2}Daniel Richardson. ¹Brighton and Sussex University Hospitals NHS Trust, Brighton, UK; ²Brighton and Sussex Medical School, Brighton, UK

10.1136/sextrans-2017-053232.54

Introduction Chlamydia trachomatis (CT), including Lymphogranuloma venereum (LGV), Neisseria gonorrhoeae (NG), syphilis and herpes simplex (HSV) all cause proctitis in MSM. Local guidance recommends testing and treating for these organisms. We examined the aetiology and management of cases of proctitis at our sexual health clinics.

Methods Clinical records were reviewed of all men coded for proctitis between January and December 2016. Clinical presentation, microbiology results, and treatments issued at initial clinic visit were recorded and data analysed.

Results 46 MSM were correctly coded as having proctitis. The median age was 38.5(19–75) years. 21/46(45.7%) were HIV-positive. Presenting symptoms included: rectal discomfort (69.6%), discharge(47.8%), bleeding(39.1%), altered bowel habit(23.9%), and tenesmus(17.4%). 7/46(15.2%) had anorectal ulceration.

All patients were tested for CT and NG. NG was detected in 11/46(23.9%) and CT in 10/46(21.7%), including 4 with LGV. 27/46(58.7%) were tested for HSV, which was positive in 8/27(29.6%). 1 Mycoplasma genitalium and 4 Syphilis were diagnosed. Co-infections with >1 organism were identified in 8(17.4%). In 22/46(47.8%) no cause was identified. 41/46 (89.1%) MSM received antibiotics for CT. In 30/46(65.2%) MSM this included anti-microbial cover for NG and 17/46 (37.0%) had an extended course of doxycycline for LGV. Aciclovir was given to 12/46 MSM (26.1%).

Discussion NG was the commonest pathogen identified, however only 65% of MSM were treated. HSV testing rates were low despite one third of those tested being HSV positive. This indicates a need to better educate clinicians of the multi-pathogen, syndromic, approach to proctitis management to ensure that relevant pathogens are not missed.

P009 RISK OF CHLAMYDIA/GONORRHOEA NAAT CONTAMINATION FROM CLINIC SURFACES – NEED FOR PATIENT AND STAFF AWARENESS IN SELF-SWABBING AND POOLING AREAS

Harriet Wallace*, Sharon Daley, Michelle Loftus-Keeling, Janet Wilson. Leeds Sexual Health, Leeds Teaching Hospitals Trust, Leeds, UK

10.1136/sextrans-2017-053232.55

Introduction A self versus clinician Chlamydia/gonorrhoea (CT/NG) NAAT swab trial, with pooling of self-taken samples, recruited January 2015–September 2016. There was concern that nucleic acid contamination of clinic surfaces could be a source of false-positive samples during the pooling process.

Aim(s)/objectives To ascertain levels of environmental nucleic acid contamination within clinic environments. To determine number of false positive pooled samples throughout study.

Methods Environmental samples of clinic rooms, sluices and toilets were performed and tested using Aptima Combo 2 throughout duration of study. In November 2015, the clinic relocated from old premises to a newly renovated site.

Results were disseminated to staff throughout to raise awareness and to reduce risk of contamination during sampling/pooling. Posters in self-swab areas highlighted risk of contamination, importance of handwashing and no surface contact for swabs.

Results Of 41 environmental sampling episodes over 12 months, 17 (41%) were CT/GC positive/indeterminate. These were distributed throughout the whole 12 months. Positive results were obtained from surfaces in all clinical examination rooms at the old site and toilets and sluices (where urines were pipetted) at both sites. 3/4 clinic rooms regularly used for examination at the new site remained contamination free. There were 7 false positive pooled samples (6 female, 1 male); all were in the first 6-months of the study.

Discussion Nucleic acid contamination was repeatedly found throughout the clinic despite regular cleaning/decontamination. Raising staff and patient awareness did not reduce contamination but it did reduce false positive pooled samples, with none occurring after the first 6-months.

P010 ROUTINE USE OF DOXYCYCLINE FOR FIRST-LINE CHLAMYDIA TREATMENT: HOW HARD CAN IT BE?

Megan Joyce*, Lucy Worlock, John White. Guy's and St Thomas' NHS Foundation Trust, London, UK

10.1136/sextrans-2017-053232.56

Introduction BASHH guidelines advise either azithromycin 1g stat or doxycycline 100mg bd 7 days as first line treatment for uncomplicated Chlamydia infection. In practice, azithromycin 1g is favoured in many clinics due to perceptions of better adherence, tolerability and efficacy. Evidence has mounted of suboptimal efficacy of azithromycin, yet guidelines and practice remain unchanged. We routinely use doxycycline as first line treatment for Chlamydia infection. We sought to audit this practice, investigate rates of intolerance and adherence and explore treatment failure in those who had follow-up testing.