

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

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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

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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?

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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.

Methods For all patients treated for Chlamydia during Jan-Mar 2016 we extracted clinical and treatment information from notes and follow-up phone calls. We collated results of patients who had a repeat Chlamydia test performed within 6 months after treatment.

Results Data were available for 215 Chlamydia-positive patients: 82 heterosexual men, 66 MSM and 67 women; 96 were treated as symptomatic patients or Chlamydia contacts and 116 were recalled for treatment. Overall 92% were treated with doxycycline. From follow-up data only 3.0% reported failing to complete treatment, citing vomiting and forgetting to take tablets as reasons. 40% of patients had a repeat Chlamydia test within 6 months, with a 14% positivity rate. All such patients had either on-going sexual risk or evidence of failed PN.

Discussion Discontinuation rates and evidence of persistent infection are low with routine use of doxycycline for Chlamydia. Clinics reluctant to make a switch to first-line doxycycline for Chlamydia and NGU might find these data useful.

P011

TREPONEMA PALLIDUM PCR (TP-PCR) IS A USEFUL DIAGNOSTIC TEST IN ADDITION TO SYPHILIS SEROLOGICAL (STS) AND DARK GROUND MICROSCOPY IN EARLY DIAGNOSIS OF PRIMARY SYPHILIS

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Introduction There has been a significant increase in infectious syphilis in men who have sex with men (MSM) since 2000. We have been using a local Tp-PCR in conjunction with dark ground microscopy and serology in patients with genital ulcer disease to increase the sensitivity of primary syphilis diagnosis. The aim of this project was to evaluate the increased diagnostic yield that Tp-PCR offers our service.

Methods We reviewed the microbiology (syphilis serology and Tp-PCR) of patients coded as primary syphilis between December 2015 and December 2016. We also collected demographic data on these cases.

Results 74 patients were accurately coded as having primary syphilis all of whom were MSM (24/74(32%)) HIV positive). STS was requested in 73 patients and 69/73(94.5%) tested positive. Tp-PCR was requested in 41 patients and 35/41 (85.4%) tested positive. DGM was performed in 13 patients and 5/13(38.5%) tested positive. Both STS and Tp-PCR were requested in 40 patients: 30/40(75%) tested positive for both, 6/40(15%) tested positive only for STS and 4/40(10%) tested positive only for Tp-PCR (one had PCR which was negative). One patient had positive Tp-PCR but no STS result available.

Discussion During a 12 month period 74 patients were diagnosed with primary syphilis. 40 had combined STS and Tp-PCR – within this cohort 10% (4/40) had confirmed primary syphilis due to Tp-PCR as STS was negative and DGM was either negative or not tested. The addition of Tp-PCR provided an opportunity for early confirmation of syphilis.

P012

HIGHLIGHTING CLINICAL NEED IN DIAGNOSING MYCOPLASMA GENITALIUM INFECTION: USE OF A MODIFIED DELPHI APPROACH TO OBTAIN A UK PERSPECTIVE

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Introduction Despite *Mycoplasma genitalium* (MG) being increasingly recognised as a genital pathogen in men and women, commercial testing has only recently become available. The opinion of sexual health clinicians and allied professionals was sought on how MG testing should be used.

Methods 32 consensus statements were developed by an expert group and circulated to clinicians and laboratory staff who were asked to evaluate their level of agreement with each statement; 75% agreement was set as the threshold for defining consensus for each statement. A modified Delphi approach was used and high levels of agreement obviated the need to test the original statement set further.

Results 60 respondents returned questionnaires, most (48) being sexual health consultants. More than 10% of UK GUM consultants therefore responded. 27 (84.4%) of the statements exceeded the 75% threshold for consensus. Respondents strongly supported MG testing of patients with urethritis or PID, or unexplained persistent vaginal discharge, or post-coital bleeding. Fewer favoured testing patients with proctitis and support was divided for routinely testing chlamydia-positive patients. Testing sexual contacts of MG-positive patients was supported, as was a test of cure for MG-positive patients by most respondents, although agreement fell below the 75% threshold. Respondents agreed that all level 3 services should have access to testing for MG (98.3%).

Discussion There was strong agreement for having MG-testing available for specific patient groups, which may reflect concern over antibiotic resistance and the desire to comply with clinical guidelines that recommend MG testing in sexual health clinic settings.

P013

THE INTRODUCTION OF PHARYNGEAL CHLAMYDIA AND GONORRHOEA SAMPLING IN A YOUNG PERSONS' CLINIC TO ASSESS FOR THE POSSIBILITY OF PHARYNGEAL ONLY INFECTION THAT WOULD HAVE OTHERWISE BEEN MISSED

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Introduction Prior to April 2016 the policy in the clinic was to 'Consider taking a pharyngeal Chlamydia and Gonorrhoea swab in conjunction with exposure, history and symptoms' in heterosexual males and females. However, in practice pharyngeal swabs were almost never taken from heterosexual patients