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

and only routinely taken from men who have sex with men (MSM). Recent studies suggest that gonorrhoea and chlamydia infections are being missed by taking vulvovaginal and urethral samples only. Therefore, it was decided to take throat swabs for chlamydia and gonorrhoea from all patients aged 20 and under that attended the dedicated Young Persons' Clinic for one year. The findings so far will be presented here.

Results A total of 225 YPC attendees had a throat swab taken between April 2016 and February 2017. Twenty-five out of 225 patients (11%) were found to have pharyngeal chlamydia or gonorrhoea. Five patients had pharyngeal chlamydia and twenty had pharyngeal gonorrhoea. A significant number, fourteen of the twenty-five (56%), had pharyngeal chlamydia or gonorrhoea only with no genital infection. Gonorrhoea was detected in twenty patients' throats and chlamydia in five. Pharyngeal cultures were taken from eleven out of the twenty gonorrhoea patients, three of which were macrolide resistant and two macrolide intermediate.

Discussion Prior to the study throat swabs were not routinely being taken from heterosexual patients. More than half of patients with pharyngeal infection had no genital infection and would not have received treatment under the current clinic guidelines. These are significant findings which may lead to a change in practice in the service.

P014 DOES SEPARATION OF HIV AND SEXUAL HEALTH SERVICES AFFECT THE MANAGEMENT OF STIS IN PEOPLE LIVING WITH HIV?

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Introduction The presence of a bacterial STI increases the risk of HIV transmission. It is important that people living with HIV have easy access to STI treatment and that partner notification is robust. In our local area, HIV care is located and commissioned separately from the sexual health service. Does this affect STI treatment and partner notification?

Methods All HIV positive patients with a diagnosis of gonorrhoea, Chlamydia or new/infectious syphilis during 2015 were identified from laboratory results and computer records. Demographic details for each patient were recorded and the management of their STI assessed according to BASHH standards.

Abstract P014 Table 1 Impact of separation of HIV and sexual health services

Infection	Number of patients	Mean interval between test and informing patient (days)	Mean interval between informing patient and attendance for treatment (days)	Mean number of partners attending within 4 weeks [BASHH standard]
Gonorrhoea	24	14.6	4.5	0.375 [0.6]
Chlamydia	23	13.3	4.8	0.348 [0.6]
Syphilis	16	22.6	40.2	0.125 [0.4]

Results

Discussion Barriers to timely treatment included difficulty contacting patients, need to travel to a different service to obtain medication and difficulty arranging appointments at acceptable times. Particular delays were noted in the management of syphilis. Clarification of each service's responsibilities with regard to contact tracing could improve partner notification rates. Even when HIV and sexual health services are not jointly commissioned, it is essential that both departments work together to develop robust pathways for the management of STIs identified in people living with HIV.

P015 RECEIVING 1G AZITHROMYCIN AS PART OF MASS DRUG ADMINISTRATION (MDA) FOR THE CONTROL OF TRACHOMA IS ASSOCIATED WITH REDUCED GENITAL MYCOPLASMA GENITALIUMPREVALENCE

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Introduction Mass Drug Administration (MDA) with 1g oral azithromycin for ocular *Chlamydia trachomatis* (CT) infection, a key component of trachoma control, can concomitantly reduce genital CT prevalence. However, this dose is known to be sub-optimal for the treatment of genital *Mycoplasma genitalium* (MG) infection. Here we investigate factors associated with MG infection in pre- and post-MDA sample sets.

Methods Pre-MDA (T1) and 6 months post-MDA (T2) CT-negative self-collected vulvo-vaginal swabs from women attending three outpatient antenatal clinics (Honiara, Solomon Islands), were tested for MG infection using nucleic acid amplification. Logistic regression was used to determine factors associated with infection. Variables tested included: patient age, clinic attended, ethnicity, time spent in education, living in an urban or rural environment, marital status, living with spouse, presence of symptoms associated with a sexually transmitted infection (STI), having an STI in the last 12 months, current CT, Gonorrhoea or *Trichomonas vaginalis* infection, and at T2 only receipt of MDA dose.

Results MG positivity was found in 11.9% (95%CI: 8.3–16.6; 28/236) of women at T1 and in 10.9% (95%CI: 7.7–15.4; 28/256) at T2 (p=0.7467). The only factor associated with having an MG infection was history of not having received MDA with azithromycin at T2 (odds ratio 0.19, 95%CI 0.07–0.53, p=0.001).

Discussion Not having MG infection was associated with receiving 1g azithromycin as part of MDA for trachoma control six months previously. However there was no overall drop in population prevalence, indicating individual but not population benefits of MDA with regard to MG infection control.

P016 CLINICAL UTILITY OF A MYCOPLASMA GENITALIUM (MG) REFERRAL DETECTION ASSAY IN SELECTED SEXUAL HEALTH CLINIC ATTENDEES

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