

Results Mean age was 34 (17–65); 92% male; 75% white; 86% MSM. 415 site specific infections captured. Site distribution by NAAT, culture concordance/sensitivities, and TOC are presented below:

Abstract P028 Table 1 Gonorrhoea infections

NAAT+ by SITE	Sexuality			Culture results			Test of Cure	
	MSM	Hetero – Male	Hetero – Female	Cultures taken	Culture negative	Cipro- floxacin resistance	TOC Done	TOC Failure
VVS	NA	NA	7% (21/ 300)	76% (16/21)	19% (3/16)	7.6% (1/13)	76% (16/ 21)	0% (0/16)
Urethra	42% (126/ 300)	7% (21/ 300)	NA	90% (132/147)	3.7% (5/132)	33% (43/127)	53% (78/ 147)	2.6% (2/78)
Pharynx	37% (111/ 300)	0.7% (2/300)	1% (3/300)	68% (79/116)	51% (37/72)	43% (18/42)	66% (77/ 116)	5.2% (4/77)
Rectum	43% (128/ 300)	0.3% (1/300)	0.7% (2/300)	63% (83/131)	12% (10/83)	48% (35/73)	65% (85/ 131)	3.5% (3/85)

75% NAAT+ patients (310/415) had cultures performed. There was one case of ciprofloxacin and azithromycin resistance (MSM). 96% (287/300) received ceftriaxone plus azithromycin. Reasons for alternatives related to penicillin allergy. Median time to treatment 0 days (0–45d). 63% (189/300) attended for TOC (median time: 21d (7–188d)) and 94% (177/189) patients tested negative. Failed TOC was due to reinfection in 92%.

Discussion Our clinics maintain reasonable adherence to BASHH standards. Cephalosporin resistance was not observed. TOC times can be lengthy.

P029 AUDITING GONORRHOEA TREATMENT AND ANTIBIOTIC SENSITIVITY

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Introduction With diagnoses of Gonorrhoea on the rise and increased rates of resistance being reported, nurses carried out and audit to establish the level of compliance with current British Association of Sexual Health and HIV guidelines in relation to the treatment of patients diagnosed with GC and to analyse antibiotic sensitivity.

Methods Retrospective case note review of episodes coded B was carried out looking at age, ethnicity, sexual orientation, co-infections, treatment, resistance, number of partners in past 3 months, test of cures and follow up serology.

Results 69 cases reviewed, 33 MSM, 32 heterosexual, 4 bisexual. 10 patients were known HIV positive, 12 patients had 1 other co-infection, 4 had 2 other co-infections.

66 (96%) treated with first therapy of Ceftriaxone 500mg IM/Azithromycin 1G, 19 of these were also given Doxycycline 100mg twice daily for 1 week. 2 (3%) treated with Ceftriaxone 500mg IM/Doxycycline 500mg twice daily for 1 week. 45 (65%) fully sensitive to recommended antibiotics 13 (19%)

reduced sensitivity to 1 antibiotic group 8 (11%) reduced sensitivity to 2 antibiotic groups. 4 (5%) reduced sensitivity to 3 antibiotic groups. Our 5 cases of high level Azithromycin resistance were included. No cultures were resistant to Ceftriaxone

Discussion Treatment and management was in line with BASHH guidelines, it also highlights the developing problem with resistant infection, the importance of monitoring antibiotic sensitivity and effective partner notification in the effort to treat the infection adequately and reduce risk of transmission.

P030 MANAGEMENT OF RECTAL CHLAMYDIA IN AN URBAN SEXUAL HEALTH CENTRE

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Introduction We reviewed management of rectal chlamydia in our clinic and adherence to 2015 BASHH audit standards.

Methods Electronic patient records of 100 consecutive patients diagnosed with rectal chlamydia prior to 31 July 2016 were reviewed with respect to gender, sexuality, HIV status, symptoms, STI screening, treatment, test of cure (TOC) and partner notification (PN).

Results 64% were female (all heterosexual). 94% males were MSM; 18% were HIV positive. 1 male presented with rectal symptoms (pain). 23% patients had other genital symptoms. 76% were asymptomatic. 71% had concomitant STIs (including chlamydia at other sites). 90% received doxycycline 100mg bd for at least 1 week. 24% were treated with azithromycin before being recalled for doxycycline. Reasons included; not initially tested for rectal infection, attendance as a contact, initial treatment for presumed GC. All patients were advised to attend for TOC; 58% attended. All TOC were negative. All HIV positive patients were tested for LGV (1 positive). 1 MSM with rectal pain was not tested for LGV but subsequent TOC was negative. 36% received written information. PN was performed in 99% of cases with 81% of traceable contacts reported as attended and 47% of contacts being verified as attended.

Discussion High numbers of patients were issued with azithromycin as initial treatment requiring recall for doxycycline. This is concerning, particularly in an era of increasing antibiotic resistance. Education sessions have been provided, highlighting the importance of sexual history taking and use of doxycycline as first line chlamydia treatment where rectal infection is possible.

P031 EPIDEMIOLOGICAL STUDY ON SYPHILIS DIAGNOSES AT A LOCAL GENITOURINARY CLINIC (GUC)

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Introduction In 2015 our country reported 11.5 confirmed syphilis cases per 100 000 population, which is one of the highest rates in Europe. The objective of our study was to analyse the epidemiological characteristics of patients diagnosed with syphilis.

Methods A retrospective analysis of medical records of patients attending the local GUC with a diagnosis of syphilis from 2002–2015 was carried out. Data concerning patient demographics (age, gender and sexual orientation), year of diagnosis, syphilis stage, treatment regime, HIV/STIs co-infections, partner notification and follow up were recorded.

Data collected was inputted in an excel database.

Results In the study period a total of 291 patients were diagnosed with syphilis. 82.6% were males (n=238); 48.6% (n=143) were MSM and 5.2% (n=5) bisexual men. Syphilis was diagnosed in the primary stage in 11.3% of patients, secondary in 9.6%, early latent in 30.9% and late latent in 47.4%. All patients with syphilis were tested for HIV and 16.1% (n=147) resulted HIV positive, 74.5% of them (n=35) were MSM. Partner notification was not possible and/or not reported in 40.5% (n=118) of patients. In 21% (n=61) of cases, it was not possible to establish whether the treatment was successful because these were lost to follow up.

Discussion As the syphilis rates continue to rise so rapidly, it is very important to have robust mechanisms in place to limit spread such as proactive recall for treatment and follow up and education and support regarding safer sexual practices.

P032 CHARACTERISTICS OF A HIGH SYPHILIS INCIDENCE COHORT IN AN INNER-CITY LONDON CLINIC

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Introduction Syphilis cases continue to increase in London. We aimed to investigate the characteristics and risk factors of patients diagnosed with syphilis at our centre.

Methods Retrospective case note analysis of all syphilis cases diagnosed in our sexual health clinic in 2016.

Results 56 cases were identified; mean age was 42 (range 16–69 years), with 80% male. The two commonest ethnicities were Black Caribbean (20%) and White Other (20%). 18% were HIV positive, and 18% had concomitant STIs, with one new HIV diagnosis. 26% had been treated for syphilis previously.

Just under a third of patients were symptomatic, the rest being identified through routine screening in clinic or through online testing. Just over a fifth of the cases (12/56) were primary syphilis, with secondary syphilis diagnosed in 7% of patients. All primary and secondary syphilis cases occurred in MSM, and there was a correlation with reported chemsex, with 38% prevalence.

Two of the patients were vulnerable, one being a vulnerable child aged 16. One of the patients was on PREP.

There were 21 cases in heterosexual patients, all were late latent syphilis. Heterosexual men were older (mean 50 years); most heterosexual patients came from regions with high syphilis rates and endemic treponematoses.

Discussion There is high ongoing transmission of syphilis in MSM in our cohort, linked to risky sexual practices and drug use. Increased awareness of syphilis symptoms might facilitate earlier presentation to clinics. As many patients were asymptomatic, there is a pressing need for regular screening in high risk groups.

P033 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEAE

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Introduction We present a retrospective analysis of clinic performance in the 5 domains of management and treatment of Neisseria gonorrhoeae (GC) according to current British Association of Sexual Health and HIV (BASHH) guidelines.

Methods All cases of GC diagnosed at our clinic between 1st January and 30th June 2016 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared with data from the same clinic for the same six months (1st January to 30th June) in 2007–2015.

Results 87% of patients treated for GC were recommended to have a test of cure (TOC) (61% had a TOC.). 100% of with GC were screened for Chlamydia trachomatis or received presumptive treatment for this. 88% of patients with GC had partner notification carried out. 56% of patient's received written information about GC. 97% of patients with GC received 1st line treatment, or the reason for not doing so was documented.

Discussion We have demonstrated consistent improvement in 2 of the 5 domains compared with previous years' data. Recommending a test of cure, partner notification and offering patient information leaflets have decreased over the last year. To address this, teaching sessions were carried out and a quality improvement project to ensure patient information leaflets are offered is underway.

Further staff training and awareness of management of N. gonorrhoeae will be addressed on a regular basis and a re-audit is recommended next year.

P034 ASSOCIATION OF MYCOPLASMA GENITALIUM AND PERSISTENT ABDOMINAL PAIN- WHAT SRH DOCTORS UNDERTAKING ULTRASOUND NEED TO KNOW?

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Introduction The 2016 European guideline on Mycoplasma Genitalium (MG) states that significant association is found between MG and pelvic inflammatory disease (PID). MG is diagnosed through nucleic acid amplification testing. The aim of this study was to find out about the importance of testing for MG in patients with persistent abdominal pain.

Methods It was a retrospective analysis of patients who were tested for MG in Sexual and Reproductive healthcare (SRH) consultant ultrasound clinic over a period of 17 months. The inclusion criterion for testing was persistent symptoms after PID treatment.

Results 9 patients were tested for MG in consultant led SRH ultrasound clinic. All were initially treated by other clinicians for PID with standard treatment but did not respond and were referred to SRH ultrasound clinic to exclude other pathology. Ultrasound for all of the patients was normal with no adnexal masses or free fluid. Pregnancy test was done in all cases and it was negative; all patients were also negative for chlamydia and Gonorrhoea. MG testing was done in all 9