cases and 2 came back positive (22%). Both were treated with Moxifloxacin 400mg OD for 10 days.
Discussion This small study shows that there can be an association between persistent abdominal pain and MG. SRH doctors who are undertaking ultrasound on a routine basis should consider possibility of MG testing in patients with persistent abdominal pain. More research is needed in this area to establish a routine testing for MG in a patient with abdominal pain.

Contraception and Reproductive Health

P035 QUICK STARTING HORMONAL CONTRACEPTION AFTER USING ORAL EMERGENCY CONTRACEPTION: A SYSTEMATIC REVIEW

[1,2]Lauren Murphy*, [3]Zhong Chen, [3]Valerie Warner, [1]Sharon Cameron. *[1]Department of Reproductive and Developmental Sciences, Edinburgh, UK; [2]Brighton and Sussex Medical School, Brighton, UK; [3]Chalmers Centre, Edinburgh, UK*

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Introduction Unprotected intercourse after oral emergency contraception (EC) significantly increases pregnancy risk. This underlies the importance of promptly starting effective, ongoing contraception – known as 'quick starting.' However, theoretical concern exists that quick starting might interact with EC or hormonal contraception (HC) potentially causing adverse side effects.
Methods A systematic review was conducted, evaluating quick starting HC after oral EC (levonorgestrel 1.5mg [LNG] or ulipristal acetate 30mg [UPA]). PubMed, EMBASE, The Cochrane Library, ICTRP, ClinicalTrials.gov and relevant reference lists were searched in February 2016. A lack of comparable studies prevented meta-analysis.
Results Three randomised controlled trials were identified. Two biomedical studies suggested HC action was unaffected by quick starting after UPA; one study examined ovarian quiescence (OR: 1.27; 95% CI 0.51 to 3.18) while taking combined oral contraception (COC). Another assessed cervical mucus impenetrability (OR: 0.76; 95% CI 0.27 to 2.13) while taking progestogen-only pills (POP). Quick starting POP reduced the ability of UPA to delay ovulation (OR: 0.04; 95% CI 0.01 to 0.37). Side effects (OR: 1.22; 95% CI 0.48 to 3.12) and unscheduled bleeding (OR: 0.53; 95% CI 0.16 to 1.81) were unaffected by quick starting COC after UPA. Another study reported higher self-reported contraceptive use at eight weeks among women quick starting POP after LNG, compared with women given LNG alone (OR: 6.73; 95% CI 2.14 to 21.20).
Discussion Limited evidence suggests quick starting HC after UPA does not reduce HC efficacy, however it reduces UPA efficacy. Consequently, women should delay starting HC after UPA.

P036 IMPROVING LARC UPTAKE: A RETROSPECTIVE STUDY INTO THE ROLE AND IMPACT OF ENHANCED SEXUAL HEALTH SERVICES IN COMMUNITY PHARMACIES

Anthony Peacham*, Merle Symonds, Liat Sarner. *Barts Health NHS Trust, London, UK*

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Introduction Unwanted pregnancies and low uptake of LARC continues to be problematic in 15–44 year olds in an East London Borough. Between April 15 and March 16, 45 pharmacies were commissioned, as part of the local enhanced sexual health service (LES) to provide emergency hormonal contraception (EHC) and contraception advice with the aim of increasing LARC uptake in <25s and others at high risk of unwanted pregnancy. Pharmacies taking part in the pilot received PGD and safeguarding training and pathways into LARC were refreshed.
Methods Analysis of self-sample STI tests via the Doctor's Laboratory and consultations documented via PharmOutcomes, and corresponding search of PreView for attendances for contraceptive/LARC care during time period.
Results 35/45 pharmacies (77.8%) dispensed 324 Levonorgestrel (1500 microgram) doses to women resident in the borough >13 years (average age 24.9 years; range 14.2-49.6 years). 100% of <16s had Fraser competency assessed (4). 6.2% (20/324) women had >1 attendance for EHC. 16 women (4.9%) subsequently attended local CaSH/GUM services for LARC; 8 (2.5%) for implant; 4 (1.2%) for injectable; 4 (1.2%) for IUD.
Discussion Pharmacy delivered EHC and signposting to LARC services in primary and secondary care is feasible. There were limitations in the ability to gather data regarding women accessing LARC in primary care following contact with pharmacy so these numbers may under report the actual figures of those accepting LARC following pharmacy contact. Online booking systems should be accessible to pharmacists to facilitate LARC referral. Further work looking at acceptability of this strategy should be conducted.

P037 WHY DO WOMEN DISCONTINUE LONG ACTING REVERSIBLE METHODS OF CONTRACEPTION? – FINDINGS FROM AN INTEGRATED SEXUAL HEALTH CLINIC

Izu Chikoburo, William Dear, Omi Ohizua, Sashi Acharya*, Joseph Arumainayagam. *Walsall Manor Hospital, Walsall, UK*

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Introduction Long acting methods of contraception, namely the progestogen only implant and the intra-uterine devices are reliable methods of contraception, favoured by commissioners of integrated sexual health. However in practice, a number of women discontinue these for a variety of reasons thus leading to reduced cost effectiveness. We aimed to determine the number of discontinuations among those who had them fitted in the integrated sexual health clinic and the reasons for doing so.
Methods Retrospective analysis of the case notes on the electronic database for all women who had an implant, copper intra-uterine device or the Mirena intra-uterine device during September 2014 was collected. Reasons noted by the clinician for removing the device and any adjuvant therapy that was prescribed was noted.
Results A total of 183 women had one of the three methods fitted during this period. Of these 36% had them removed after a median of 2.16 years. Of those who had the implant fitted, 49% had them removed after a median of 1.84 years. Vaginal bleeding was quoted as the reason for removal in 51% of the women. Of the 25% of the women who had the