Methods We looked at cases of hepatitis C diagnosed in our sexual health/HIV service per calendar year from 2012 – 2016 and looked at HIV status, injecting drug use and sexual behaviour.
Results We saw 37,012 attendances for sexually transmitted infection testing by MSM in the study period: There were 9 diagnoses of hepatitis C in HIV negative MSM in the study period. (2012:3, 2013:3, 2014:1, 2015:2, 2016:0). 5/9 HIV negative MSM diagnosed with hepatitis C gave a history of IDU. 4/9 HIV negative MSM diagnosed with (incident) Hepatitis C had no documented history of IDU, all had a recent history of condom-less anal sex at chem-sex parties; 2/4 had engaged in fisting and none were using PrEP at the time of diagnosis.
Discussion There appears to be a very small amount of hepatitis C transmission in HIV negative MSM who do not inject drugs associated with condom-less anal sex at chem-sex parties and fisting. Screening for hepatitis C could be rationalised to these groups of MSM.

O07 NATIONAL RESPONSE TO AN OUTBREAK OF HEPATITIS A ASSOCIATED WITH MEN WHO HAVE SEX WITH MEN IN ENGLAND, 2016/2017

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Introduction Hepatitis A virus (HAV) is a vaccine-preventable infection, mainly travel-associated in the UK. Since July 2016 Public Health England has detected an increase in hepatitis A laboratory notifications in men who have sex with men (MSM). We described the outbreak characteristics to inform implementation of nation-wide control measures.
Methods A confirmed case was defined as a HAV infection with one of three outbreak strains and symptom onset after 31//6/16. Demographics, travel history and sexual behaviours were collected using a questionnaire.
Results By February 2017, 73 confirmed cases were detected across England. Of these 58 identified as MSM (median age 36 years) and 28 reported travel within the incubation period, primarily to Spain. 25% reported >1 casual partner in the previous 8 weeks. In addition to supporting the local public health response, PHE collaborated with national STI, HIV and liver associations to refine immunisation recommendations for at-risk MSM and alert front-line clinicians, and worked with the NHS and sexual health charities to raise awareness and promote personal hygiene and immunisation among MSM via social media, posters and leaflets.
Discussion The outbreak is likely associated with other MSM outbreaks with the same strains in other UK and European countries. The investigation suggests initial multiple importations from abroad followed by secondary sexual transmission within the MSM population in England. This outbreak highlights the need for MSM and healthcare professionals to consider the potential of HAV as a sexually transmitted infection, and the need to consider immunisation of MSMs where recommended.

O08 HPV 16 AND 18 SEROPOSITIVITY AND DNA DETECTION AMONG MEN WHO HAVE SEX WITH MEN: EVIDENCE FOR THE POTENTIAL BENEFIT OF VACCINATION

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Introduction To estimate the prevalence of antibodies to HPV16 and HPV18, and genital HPV DNA among MSM attending a London sexual health clinic, to inform the potential benefit of vaccination in a high risk population.
Methods A cross-sectional study of 18-40 year-old MSM including a computer-assisted self-interview for behavioural data, and collection of extra-genital and intra-anal swabs, and blood. Anogenital samples were tested for 21 genotypes of HPV DNA using an in-house assay. Blood samples were tested for anti-HPV16 and HPV18 IgG by ELISA.
Results 496 MSM were included: among HIV negative MSM, HPV16 seroprevalence was 27% (95%CI 23–31) and HPV18 was 16% (13–20); HPV16 and 18 DNA prevalence 12.6% (9.8–15.9) and 6.0% (4.0–8.5) respectively. In HIV-positive MSM, seroprevalence was 58% (95% CI 37–77) and 35% (95%CI 17–56), and DNA prevalence 29.6% (13.8–50.2) and 11.1% (2.4–29.2) respectively.

After adjusting for age and lifetime partners, seropositivity for anti-HPV–16 and/or HPV–18 was associated with: HIV-positive diagnosis (HPV16-aOR: 3.16 [95%CI 1.37–7.28]), receptive anal sex in the last three months (HPV16-aOR: 3.39 [2.01–5.71]; HPV18-aOR: 2.14 [1.18–3.90]), use of drugs anally (HPV18-aOR: 2.07 [1.05–4.10]) and anogenital same-type DNA detection (HPV16 aOR: 3.58 [2.05–6.23]; HPV18 aOR:2.71 [1.17–6.27]).
Discussion Anogenital HPV DNA detection was less frequent than, but strongly associated with same-type HPV seropositivity. Most MSM attending a sexual health clinic had no serological or DNA evidence of exposure to HPV infection. This supports the case for the potential benefit of targeted HPV vaccination of MSM attending sexual health clinics, as currently being piloted in England.

O09 THE IMPACT OF AN HPV VACCINATION PROGRAMME IN YOUNG MEN WHO HAVE SEX WITH MEN (MSM) ON CLINICAL PRESENTATIONS WITH GENITAL WARTS

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Introduction We introduced a quadrivalent HPV (HPV4) vaccination programme in young MSM <27yrs attending our clinical services (Clinic 1 & 2) since 2012. We assess the impact on attendance with genital warts (GW) subsequent to vaccination in this population and an adjoining service (Clinic 3) not then offering vaccination.

Methods We identified all MSM <27yrs receiving at least one dose HPV4 at Clinics 1 & 2, and all MSM <27yrs attending Clinic 3, between 2012 and 2017. Demographic and clinical data was extracted from electronic patient records. HPV DNA testing was not performed.

Abstract O09 Table 1 Clinical Outcomes in HPV4 vaccinated and unvaccinated MSM under 27yrs

Characteristic	Clinic 1& 2 HPV programme No./Total (%)	Clinic 3 No HPV programme No./Total (%)	Probability value p =
History of prior/current GW	75/757 (9.9%)	27/180 (9.6%)	p = 0.06
Ever Re-attended	524/757 (69%)	81/180 (45%)	p = 0.0001
Subsequent episode of GW: Re-attenders	11/524 (2%)	22/81 (27%)	p = 0.0001
Subsequent episode of GW: All	11/757 (1.5%)	22/180 (12%)	p = 0.0001
New cases of GW	3/757 (0.4%)	4/180 (2%)	p = 0.0285

Results Current or prior history of GW was comparable in the 2 clinic populations. Re-attendance rates were lower in the clinic without active recall. Recurrent episodes of GW was higher 22/180 (12%) in the unvaccinated population than the vaccinated group 11/757 (1.5%). Incidence of new cases of GW, defined as a first clinical episode > 3 months since 1st vaccine, was significantly lower in the vaccinated population.
Discussion We observed a significant reduction in subsequent episodes and potential new episodes of GW in an unselected population of MSM receiving HPV4 vaccine. Significant clinical benefit and saving can be expected from an HPV4 programme in MSM.

O10 AETIOLOGY OF AND TRENDS IN ANOGENITAL HERPES DIAGNOSES IN ENGLAND FROM 2006–2015

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Introduction Anogenital herpes (AH), associated with significant physical and psychological morbidity, is the second most commonly diagnosed viral sexually transmitted infection (STI) in England and is caused by infection with Herpes Simplex Virus (HSV) Type-1 or Type-2. We investigated the epidemiological and serotype characteristics of AH diagnoses in England and changes over time.
Methods We performed a descriptive analysis of socio-demographic and clinical characteristics of AH using data from the national surveillance system for STIs (GUMCADv2), and calculated the proportion of new episodes by serotype using data from the national laboratory surveillance system in England from 2006–2015.
Results There were 31,312 first and 25,356 recurrent AH episodes in 2015, and diagnosis rates of first episode AH increased 55% from 38 to 59 per 100,000 population since 2006. In 2015, diagnosis rates were highest among women (73.5), people aged 20-24 (243.1), those of Black Caribbean ethnicity (176.3), and London residents (93.8). Although MSM only accounted for 4.6% (n=1430) of diagnoses in 2015, there was an 18% increase in diagnoses since 2011; overall 28% of MSM diagnosed with AH were HIV-positive. The distribution of HSV-1/HSV-2 has remained stable since 2006: in 2015, 48% of women and 36% of men with AH were diagnosed with HSV-1 infection.
Discussion Increased diagnoses of AH may be due to changes in sexual practices or improved test sensitivity. Differences by socio-demographic characteristics can be used to inform prevention strategies, while those by serotype are essential for guiding vaccine development.

O11 USING A PROFESSIONAL PATIENT MYSTERY SHOP TO EVALUATE MANAGEMENT OF RECENTLY DIAGNOSED HSV-2, COMPARED WITH DATA FROM A NATIONAL QUESTIONNAIRE

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Introduction In 2014, the British Association of Sexual Health and HIV updated guidelines detailing the expected management of Anogenital Herpes type 2 (HSV-2). This study aims to evaluate counselling given to patients with HSV-2 and determine how clinicians are dealing with sensitive topics that arise during these consultations.
Methods 210 UK Genito-Urinary Medicine (GUM) clinics were sent an anonymous questionnaire, the results of which were analysed and compared with current guidelines. A pilot mystery shopping study, involving a patient with a reported recent HSV-2 diagnosis, was performed in 3 UK GUM Clinics. Details of each consultation were graded as A (acceptable), U (unacceptable) or C (a cause for concern) by a panel of 6 experts.
Results Analysis of the returned questionnaires showed inconsistencies in answers between clinicians and guidelines. The advice given during the visits was graded 69.7% A, 16.8% C and 13.5% U. Staff performed well with providing emotional support and guiding patients to extra materials (84.5% A) but did significantly less well on topics such as disclosure (65.9% A, p=0.0025), transmission (71.8% A, p=0.032) and pregnancy (53.9% A, p=0.000013) (Pearson's Chi-squared test).
Discussion The study has exposed some short falls in clinical practice, which should be addressed by future guidelines and education events at BASHH, should they be supported by a larger-scale study. Returning anonymised data to participating clinics may allow them to deal with discrepancies in their practice.

O12 LGV TESTING: ARE WE IDENTIFYING ALL CASES IN A TIMELY MANNER?

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