Results There were 150 patients, 107 females and 43 males. Median age 32 years and range 16 – 74 years. Ethnicity: 36% were White British and 22% black Afro-Caribbean. 5 were female sex workers, 3 MSM and the rest heterosexual. 98% were symptomatic (104 had dysuria and 43 increased urinary frequency). 92% had 1 partner in the preceding 3 months.

Urinalysis was positive for leucocytes in 71, Nitrites in 55 and blood in 38 patients.

The audit standards our service achieved were: 84% of all patients who had symptoms suggestive of UTI had Urinalysis, 88% received appropriate first line antibiotics, 63% of women with pelvic pain had a pregnancy test and 100% of all male patients with a UTI were referred to Urology. 40% of MSU were positive and bacteria isolated were 73% E coli, 15% Coliform and 6% Proteus.

The table below shows sensitivities to antibiotics:

Abstract P188 Table 1 UTI antimicrobial sensitivity

	Trimethoprim sensitivity	Nitrofurantoin sensitive
Sensitive	80%	91%
Resistant	17%	9%
Intermittent	3%	0%

Discussion We are currently discussing with our local microbiologists about stopping routine MSU in line with NICE guidance and a change to nitrofurantoin as first line treatment. Staff training has been done to remind staff about the need to do a pregnancy test in women with pelvic pain.

P189 REFLECTIONS ON SCHOOL SEX EDUCATION FROM YOUNG ADULTS: A SURVEY VIA SOCIAL MEDIA

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Introduction With inconsistency of sexual education in schools, we used social media to ascertain opinions from a group aged 18-25 in the UK.

Methods A short survey of four questions was distributed via Facebook to immediate contacts to the primary author. 91 anonymous responses received (demographics not available).

Questions were • Which topics were covered in your sex education during your time in school?

• When do you think it is appropriate to begin sex education?

• Which areas of sexual education would you like to see improved?

• Is there anything that you wish you had been told during your sexual education?

The first two were multiple choice; second two were free text.

For analysis, 'sex education' was used as an umbrella term for education relating to sex (anatomy and practice), relationships, gender and sexuality. Responses for questions 3 and 4 were combined as they generated similar results.

Results Question 1:

Abstract P189 Table 1

Topics	Responses	Topics	Responses
Anatomy of sex	81(89%)	Consent and rape	26(29%)
STDs	79(87%)	Sexuality	14(15%)
Safe sex	77(85%)	Sexual harassment	11(12%)
Female contraception	58(64%)	Gender identity	3(3%)
Drugs and alcohol	58(64%)	Non-heterosexual intercourse	2(2%)

63/91 (69%) believed sexual education should begin during primary school. 31/91 (34%) wished that consent had been covered better, often combined with the implication that this lack of education had affected their personal life.

Discussion While not without limitations, our short survey gave some interesting results worthy of further exploration, suggesting that UK sexual education needs reform before it meets the needs of modern young people.

P190 GENITOURINARY MEDICINE: MORE THAN JUST STI SCREENING AND TREATMENT

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Introduction Since the transfer of commissioning, some local authorities have taken a narrow view of sexual health, defining it as STIs and contraception only, and some have not funded the complex non-STI genital conditions that are a core part of GUM. However patients attend because they have a problem, which may or may not be an STI, that affects their sexual health. We aimed to give a snapshot of a GUM consultant's clinical caseload.

Methods A record was kept of all GUM patient consultations over a 2 week period.

Results A total of 43 patients were seen. All but one were follow-ups. Nine (21%) were long-term attenders. The rest were referred by other clinic staff 20 (47%), consultants in other specialties 10 (23%) and GPs 4 (9%). The average age was 41 (19–87).

The commonest conditions seen were genital dermatoses (20), chronic/recurrent PID (13), recurrent candida (9; two with resistant species), VIN (6), atrophic vulvo-vaginitis (6), vulvodynia (5), and CPPS (4). STIs included HSV (3), chlamydial PID (3) SARA (1) and conjunctivitis (1), and an MSM with syphilis, rectal gonorrhoea and warts.

Nine patients had more than one genital infection and nine both a genital infection and a genital dermatosis.

Discussion This snapshot demonstrates both the complexity of patients and the holistic care provided by a GUM consultant. While other specialties are able to manage some of the conditions seen in GUM, few would have the expertise to manage patients with co-existing STIs and other genital infections, chronic pain conditions and genital dermatoses.