Fluconazole or Daktacort. In the remaining cases no presumptive diagnosis was made but 10 patients were given empirical Trimovate cream, three had Metronidazole tablets, one had Dermovate cream and one had Betnovate cream. Seven patients did not receive any medication. In all but one case the balanitis had fully resolved within 6 weeks. In the persistent case, initial treatment was with Clotrimazole cream for presumed Candida; when the lesions persisted this was changed to Daktacort but a clear diagnosis was not made. However, he failed to attend for further follow-up so it is not known if the balanitis resolved with the change of treatment. No cases were referred for biopsy.

Conclusion The rate of persistent balanitis was extremely low in this cohort and all except one case resolved with treatment. This patient did not return for further review and was not referred for biopsy. Penile biopsy is recommended where the balanitis persists and the diagnosis remains unclear as in this case. A robust system of recall management is needed to ensure that appropriate action is taken in such cases.

P139 EVALUATION OF A DEDICATED MULTI-DISCIPLINARY YOUNG PERSON'S INTEGRATED SEXUAL HEALTH CLINIC

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Background Our local authority has the highest teenage pregnancy rate in Scotland. A needs assessment was undertaken and a dedicated young persons (YP) clinic was introduced for people aged 18 and under in partnership with the local youth health and information centre and the child protection team.

Aim To evaluate the 6-month pilot of a dedicated YP multi-disciplinary integrated sexual health clinic.

Methods All patients attending the YP clinic between January and June 2011 were included. Data collected included demographics, sexual orientation, STI diagnoses and the uptake of contraceptives. Data were also collected from an evaluation form offered to all patients.

Results 131 young people attended the YP clinic during the pilot period. 108 (81%) were female and 23 were male of which 4 (17%) were men who have sex with men. The mean age was 16 for both males and females (range 12–18). 61 (47%) were under the age of 16. Chlamydia infection rates were high (24.4%). Sub-dermal implants were fitted in 22.2% of eligible females. 75 young people completed evaluation forms (57.3%). The majority found the clinic times suitable (95%) and travelled to the clinic by public transport or on foot (76%). Young people most frequently heard about the clinic from the local youth centre or from friends. Service users frequently commented positively on the partnership working with other agencies.

Conclusions The introduction of a YP clinic has been popular with service users. Due to the success of this service, a second clinic will be launched at the same site.

P140 SETTING UP A YOUNG PERSON'S CONTRACEPTION AND SEXUAL HEALTH (CASH) SERVICE IN A SEMI-RURAL GP PRACTICE—THE FIRST YEAR

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Background The National Strategy for Sexual Health and HIV talks about improving access to genito-urinary medicine (GUM) services by providing Level 2 services in other settings, including primary care. Rural teenagers often find it hard to access GUM services due to distance and time constraints. They may also dislike consulting their own General Practitioners (GPs) due to concerns about confidentiality.

Aims/Objectives Poor access to sexual health and family planning services was noticed in our rural area. A small Level 2 service was set up within a GP practice in January 2011. It was designed in conjunction with, and widely promoted at, local schools and colleges. A walk in service, running once a week; it offers diagnosis and treatment of most STIs, registration for C card, and all forms of contraception including long acting reversible contraception (LARC). It also offers pregnancy testing, HIV testing, signposting and advice. Emergency contraception is offered at any time of the week. There are three members of staff, a GP, practice nurse and health care assistant.

Results 432 patients were seen, with a median age of 17, drawn from a large geographical area. 75% were female and 20% under 16. New to follow-up ratio was 3:1. 261 chlamydia tests were offered with an 11% positivity rate. 137 young people have been registered for the C card, with a short education session, and LARC was discussed with 216 patients. 102 prescriptions for oral contraceptives were given and 23 injections of Depo Provera. 17 contraceptive implants and two coils were inserted. A patient satisfaction survey with a sample size of 38 showed high satisfaction ratings. Offering a service within the non-threatening environment of a GP surgery was approved highly, and most felt that their right to confidentiality had been upheld.

Conclusions In a semi-rural area, primary care can provide an effective, accessible and popular alternative to traditional CaSH services.

P141 MARKETING SEXUAL HEALTH IN A BRAND CONSCIOUS WORLD: CAN WE MAKE SERVICES MORE ACCESSIBLE TO YOUNG PEOPLE?

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Background Adolescents are media-savvy and extremely brand conscious. Much promotional material for sexual health services is poorly designed. Little has been written about how this may influence their acceptability among young people.

Objectives A new CaSH service was set up in primary care. In order to make the service appealing and accessible to adolescents, a graphic designer was recruited to create concepts and ideas for the look of the new service.

Methods Following a broad search of current CaSH websites and leaflets nationally, many were found to be poorly designed and configured, using cliched teenage imagery and language. Focus groups were set up with local young people. Six possible logos were presented, first using the suggested service name in words only, then gradually introducing each of the logo options in colour. Opinions were sought at each stage.

Results/Discussion There were widely differing views about most of the designs. Any perceived use of teenage slang, or reference to sexual health or the NHS, was rejected. Leaflets were also seen as irrelevant and boring, and leading to possible breaks in confidentiality. One logo was favoured unanimously. A poster and website were designed based on this logo to develop the brand further. In place of a leaflet, a business style card was designed, bearing only a logo and website address, enhancing the services' confidentiality. The website is the key portal for adolescents to gain information in both a confidential and informative way. Promotion in schools and pubs has led to high brand recognition. Informal feedback from service users has shown a high acceptability of the cards and the logo is perceived as contemporary and relevant.

Conclusion With brand-conscious adolescents it is worth taking care about branding of services. More research is needed to see whether approval of the brand translates into increased acceptability among teenagers, and thus into increased usage of the clinic.

P142 EVALUATING THE VULVAL SERVICE WITHIN OUR GENITOURINARY (GU) MEDICINE DEPARTMENT

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Background Vulval disorders with their psychosocial and psychosexual impact are frequently encountered within GU clinics. Dedicated specialist clinics should ideally be multidisciplinary with input from dermatology, GU and gynaecology; however this is not always feasible. A need for this service was recognised at our urban clinic—thus in 2005, a monthly vulval dermatoses clinic was set up and led by a GU physician with training in genital skin disease. In 2009 a monthly vulvodynia clinic was set up, staffed by a trained GU physician and psychosexual counsellor.
Aims To review our service provision over a 1-year period.
Methods Retrospective notes review of monthly vulval dermatoses and vulvodynia clinics were performed from November 2010–2011.
Results There were 145 vulval clinic appts; patients were only counted once—94 notes were reviewed. Vulval dermatoses clinic (n=40; 20 new, 20 f/u): median age 36 (IQR 29–44); referred by GUM 85%, derm/gynae 10%, GP 5%. Referral symptoms: itching (23), burning (8), dyspareunia (6), vulval pain (5), other (12); median length of symptoms 2 yrs (IQR 1–3). Predominant conditions were: psoriasis 28% (11) and lichen sclerosis 28% (11). Vulvodynia clinic (n=54; 24 new, 30 f/u): median age 28 (IQR 25–32); referred by GUM 67%, GP 26%, gynae/derm 7%. Referral symptoms: superficial dyspareunia (42), vulval pain (11), itching (2); median length of symptoms 2 yrs (IQR 1–5). Diagnosis of vulvodynia made in 74% (40/54). 22/40 were seen for f/u, 73% (16/22) reported at least 50% improvement in their symptoms with treatment.
Conclusion Our vulval service meets the needs of a significant number of symptomatic women allowing timely diagnosis, management and f/u. Recognising the multifactorial nature of vulval disorders means patients receive a thorough assessment in one clinic visit with a GU screen, dermatology review and psychosexual input, thus providing a service tailored to the patient.

P143 PATIENT SATISFACTION WITH THEIR SEXUAL HEALTH SERVICES IN YORKSHIRE AND HUMBER

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Background Patient derived outcome measures such as patient satisfaction surveys are a vital tool in evaluating current services and can also be used to guide future health care provision.
Aims/Objectives To undertake a re-audit of the initial survey in 2008 and incorporates specific questions about the process and experience of care that patients have received.
Methods Service users were asked to complete the questionnaire anonymously and leave it in the sealed box provided. Seven clinics across Yorkshire and Humber participated in the survey with a total of 329 questionnaires returned.
Results Compared with previous audit there were improved scores for ease of access as by then the 48-h target had been achieved in the region while the overall positive experiences of service remained high. The survey highlighted variations in the amount of time patients could expect to spend, with some reporting more than 60 min in clinic and this evidence will be helpful in influencing change. GPs and other medical services were still important sources of referral however increasingly service users used the internet to self-diagnose symptoms and obtain information about their local sexual health services. Preferences for clinic appointments were for evenings between 17:00–20:00, mornings 9:00–12:00 and afternoon's 13:00–17:00 in that order. Service user's experiences of services were overwhelmingly positive, and almost all would be happy to recommend the service to others.
Conclusions This re-audit highlighted the need for some clinics to re-examine patient flows with the aim of reducing clinic waiting times. All clinics are advised to incorporate more evening appointments. The audit also highlighted the internet as a source of information about sexual health in general and local services in particular and it is important that individual clinics address this need.

P144 CHRONIC PELVIC PAIN SYNDROME: SHOULD WE BE MANAGING PATIENTS WITH THIS COMPLEX CONDITION?

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Background Chronic pelvic pain syndrome (CPPS) affects 2%–6% of men who present to GUM departments. It is associated with a significant morbidity and there are no reliably effective treatments.
Aim To evaluate the management of men with CPPS attending a dedicated clinic.
Methods We performed a retrospective study on men with CPPS attending between September 2010 and November 2010. We extracted information regarding patient's clinical presentation, management and outcome. Outcome was quantified by the difference between the first and last scores generated by the National Institute of Health Chronic Prostatitis Symptoms Index (NIH-CPSI). A 4–6 point fall or a >25% reduction in score is considered significant. Scores can range between 0 and 43, with scores closer to 0 reflecting a more favourable status.
Results Notes were available for 19 men, mean age 38 years (Range 23–59 years). The average number of clinic visits prior to referral to the specialist clinic was 9 (Median 3.00), with a mean of 98 days from onset of symptoms (Range 21–365). 21% had urethritis and the mean number of courses of antibiotics prior to attendance was 3 (Range 0–15). All patients had a discussion on the aetiology of CPPS and the importance of pelvic floor relaxation. 16 patients received antibiotic therapy, 12 received α-blockers, 8 tricyclic antidepressants and 10 were referred to urology. The mean number of consultations was 8 (Range 2–35). The mean NIH-CPSI score fell by 8.1 (36%) ($p<0.01$). 13 out of 19 patients (68%) found a >25% improvement in their symptoms score after attending the clinic (see abstract P144 table 1).
Conclusions A significant fall in NIH-CPSI was observed in men with CPPS attending a dedicated clinic indicating that this condition

Abstract P144 Table 1 NIH-CPSI score before and after attending dedicated clinic for CPPS

	NIH-CPSI score		
Domain	First attendance	Last attendance	p Value
Pain	10.8	6.7	<0.01
Urinary symptoms	3.7	2.9	0.11
Quality of life	8.5	4.8	<0.01
Total	22.6	14.4	<0.01