relatively costly to manage. BASHH guidelines acknowledge that the evidence base for recommendations is poor. We aimed to describe the management regimes of GUM Consultants who routinely manage these conditions within our large network prior to introducing sector-wide guidelines.

Method We emailed appropriate GUM consultants from the six network centres requesting their standard management regimes for both conditions. We collated the responses and used BASHH Guidelines as a standard for comparison

Results All 14 consultants responded. Treatment regimes for VVC were broadly similar but only three consultants prescribed according to BASHH Guidelines. 13 consultants prescribed induction regimes. All consultants used oral fluconazole, doses included 50, 100 and 150 mg. Duration of induction regimes ranged from 3 daily doses, alternate day doses, 72 h doses to daily dose for 14 days. Ten consultants prescribed maintenance therapy for 6 months, 4 stopped after 3 months. 11 consultants prescribed 150 mg weekly for at least 3 months. For recurrent BV there was considerable variation and no one followed BASHH guidelines. Regimes included oral metronidazole (2 g, 400 mg), metronidazole gel or clindamycin pessaries. Induction ranged from 5 to 14 days, maintenance from 3 to 6 months. All consultants prescribed menstrual regimes if appropriate. Three consultants also prescribed Balance Activ or equivalent.

Conclusion Management of recurrent BV and VVC varied greatly across the network. Management of recurrent VVC was more closely associated with BASHH guidelines than management of recurrent BV. Management regimes are often based on clinicians' own experience. New network guidance has now been established providing a local standard for future case record audit.

P182

IS IT USEFUL TO PERFORM A FULL PHYSICAL EXAMINATION IN ASYMPTOMATIC PATIENTS WITH LATE SYPHILIS?

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Background In late and congenital syphilis a thorough physical examination should be undertaken for signs of syphilis as per British Association for Sexual Health and HIV guidelines. This should include examination of skin and mucosal surfaces, lymph nodes, the cardiovascular and neurological systems.

Aims To audit all cases of late syphilis at our centre to see if a full cardiovascular and neurological examination was documented and also to see if a full examination contributed to the management of asymptomatic patients.

Methods A total of 648 notes were identified as late syphilis from KC60 codes from our local database. Records were from the period 1994 to 2010. The following information was extracted from the clinical records: age, ethnicity, gender, sexuality, symptomatic/asymptomatic, cardiovascular and neurological examination findings and further action taken where applicable. 148 notes were unavailable. 20 notes were excluded. Therefore 480 notes in total were audited.

Results Of the 480 patients, 262 (55%) were of Black Caribbean ethnicity, 75 (16%) White British, 68 (14%) Black African and 75 (16%) others. 240 (50%) were heterosexual males, 206 (43%) heterosexual females, 31 (6%) men who have sex with men. Information on sexual orientation was not available in 3 (1%). 295 patients were asymptomatic of which 288 (98%) had normal physical examinations. Seven asymptomatic patients had positive clinical findings but these did not lead to a diagnosis of cardiovascular or neurological syphilis. In 99 cases a full examination was not documented and in 21 cases patients declined or defaulted further

follow-up. There were 65 symptomatic patients all had abnormal physical findings.

Conclusion In view of the absence of significant clinical examination findings in asymptomatic patients with late syphilis we believe that a physical examination is not a necessary element in the management of such cases and should be omitted.

P183

HOW LIKELY IS ENVIRONMENTAL CONTAMINATION OF CHLAMYDIA TRACHOMATIS DNA TO LEAD TO FALSE POSITIVE RESULTS IN PATIENTS ATTENDING OUR CLINIC?

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Background Environmental contamination with DNA from *Chlamydia trachomatis* (CT) has been reported from GUM clinics, suggesting the possibility of cross contamination of specimens during sample processing or the environment. If it does occur, contamination is likely dependent to some degree on how busy patient throughput is in a clinic. Our GUM clinic sees over 29 000 patients a year.

Aims To investigate whether diagnostic samples could become contaminated from the environment in our clinic.

Methods We investigated the potential for contamination in two ways. (1) A dummy run of 60 sterile water samples, as surrogates of urine and 10 sterile swabs during routine clinic times. (2) A patient throughput study using logistic regression analysis to see if patients positive for CT were associated with attendance numbers. We hypothesise that possible contamination increases after each infected patient and drops off to zero over the weekend. Our clinic is open from Monday to Friday and cleaned daily. Toilets are not cleaned between patients. Results were analysed for walk in clinics.

Results None of the dummy urine or swabs tested positive for CT over 6 months. In a year, 24 115 patients attended the walk in clinics with 2860 (11.9%) testing positive for CT. A logistic regression analysis was done on CT positivity on Mondays compared to Tuesdays to Fridays. This was adjusted for age, gender, sexuality and type of clinic. Rates of CT were 5% higher on Tuesdays through Fridays than on Mondays but the difference was not significant (95% CI 0.95 to 1.16).

Conclusion There was no evidence of dummy sample contamination during our study period. We found weak association between CT positivity and clinic attendance although it was not significant at the 5% level. Further studies with a larger sample size and analysis on within day trends could explore this in depth. Environmental CT is unlikely to lead to false positive results in our clinic.

P184

PEYRONIE'S DISEASE PRESENTING TO A SEXUAL HEALTH CLINIC

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Background Peyronie's disease (PD) is an acquired inflammatory condition of the corpus cavernosum of unknown aetiology. This can lead to formation of a plaque within the tunica albuginea of the penis leading to curvature and pain of the erect penis and erectile dysfunction. Medical treatment options are with colchicine or pentoxifylline.

Aim To characterise the patients who were seen between 1998 and 2011 with a diagnosis of PD.

Method Retrospective case notes review of 18 identified cases with history and signs consistent with PD.

Results The mean age of the 18 patients was 42 (range 20–63); six were Caucasians, six were from Indian subcontinent, five Africans and one Caribbean. All except one gave a history of change in penis shape during erection: six had upward curvature, seven bent to the left, one to the right, two had shortening of penis/distal flaccidity and one had no change. Seven had pain on erection, 10 had history of a penile lump, five had erectile dysfunction and two had difficulty in penetration. The mean duration of symptoms before presentation to the clinician was 64.1 months (range 3 weeks to 264 months), none had a history of penile trauma, intracavernosal injection or Dupuytren's contracture. Of four who had an ultrasound scan of the penis, two were confirmed to have lumps consistent with PD. Of 12 who had primary treatment with colchicine for 2–12 months; three showed improvement in symptoms, three no change and six unknown outcome. Of two who had primary treatment with pentoxifyline for 1–11 months one showed improvement in symptoms and one unknown. Of three who failed to respond to colchicine and were then treated with pentoxifyline, a further one showed improvement.

Conclusion (1). 28% of cases had ED. (2). Overall, 33% of the patients had symptomatic improvement with treatment and none had worsened post treatment which is consistent with the findings of other studies.

P185

A PILOT PROGRAMME FOR THE UNDERGRADUATE TEACHING OF SEXUAL HEALTH USING INTERACTIVE DEMONSTRATION FOR EXPERIENTIAL LEARNING

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Background In Edinburgh in May 2011, the GUM and FP/SRH departments integrated. A priority for the new service was reviewing and improving the undergraduate teaching offered in sexual health.

Aim To increase and improve undergraduate teaching, using experiential learning to develop the skills and attitudes essential for managing patients with sexual health needs.

Methods An OSCE format with interactive demonstration was chosen as the method to achieve these aims. Stations focused on effective communication and developing appropriate skills and attitudes. Three OSCE stations, based on common and important sexual health scenarios, were designed for interactive group work using simulated patients. The fourth station facilitated open discussion of sexuality and its implications for the well-being of patients. Four pilot sessions were run. Feedback questionnaires were given to students, facilitators and simulated patients. Strengths, weaknesses, and suggestions for improvement were requested. Participants were asked to score their level of enjoyment (from 1 to 10). Students also scored the course on how useful it was in meeting their educational needs (see abstract P185 table 1).

Results Feedback was extremely positive. Students felt the opportunity to practice their communication skills within sexual health consultations in a risk-free environment was the main strength. A request for "more scenarios" was the most commonly cited "weakness" and main suggestion for improvement.

Conclusion Following this successful pilot, the programme will now be regularly provided to the undergraduate medical students of Edinburgh. A similar model of teaching could be achieved at other

departments, and is a successful way of delivering experiential learning in teaching resource limited settings.

Abstract P185 Table 1 Participant evaluation of interactive demonstration for experiential learning

	Simulated patient	Facilitator	Student
Number of returned forms	12	25	75
"Enjoyment" mean score (1–10)	8	8	8
"Useful" mean score (Students only)			8

P186

SHOULD NURSING STAFF IN SEXUAL AND REPRODUCTIVE HEALTH (SRH) CLINICS WEAR A UNIFORM?

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Background The NHS Scotland dress code policy was implemented in 2008 with the introduction of a national uniform in 2010. Historically nursing staff within SRH clinics have chosen not to wear a uniform to create a less formal environment. Within the policy it is stated that boards should conduct a full risk assessment to ensure that local policy is appropriate for different categories of staff.

Aim To gather opinions from both patients and nursing staff about the impact of the introduction of the national uniform policy within the SRH service.

Methods A patient (n=224) and nursing staff (n=13) survey was undertaken over a 10-day period in January 2012.

Results The patient survey revealed that a minority (7%) of patients preferred that nursing staff wore their own clothes with the majority (54%) having no preference on staff dress code. The nursing staff surveys revealed that the majority work within a community health centre setting (46.2%) and were moderately happy with wearing a uniform (30.8%). Convenience was identified as a very important factor when choosing to wear a uniform (53.8%). The majority of staff agreed or strongly agreed that wearing a uniform made them more approachable (46.2%) and their role more identifiable to patients (71.6%) but they neither agreed or disagreed that it increased a patient's perception of their competency (46.2%) or enhanced professionalism (30.8%).

Discussion Although there was concern that the introduction of uniforms for sexual health nursing staff might interfere with the nurse–patient relationship this has not been realised.

P187

WORKFORCE PLANNING AND SAS DOCTORS: A CRISIS IN WAITING

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Background The importance of medical workforce planning is well recognised but it is an inexact science and has usually concentrated on consultant and trainee numbers. The difficulties in planning are complicated by a lack of information on specialty and associate specialist (SAS) doctors.

Aims We sought to aid workforce planning by collecting data from the SAS workforce to enable broader sexual health service planning.

Methods A survey monkey questionnaire was devised and sent to all SAS doctors in sexual health who were known to the British Association for Sexual Health and HIV (BASHH) or its members.