

dose tablet of PDE5i and titrated upwards if no response. Safer sex was advised.

Results Of 94 patients, 58 were Caucasian, 34 black; 58 were men who have sex with men, 35 heterosexual; 65 had a stable partner, 41 (47.8%) had >30 lifetime partners, 25 (26.5%) were >50 years; 36 (38.2%) used recreational drugs. Two were on therapeutic nitrates. Mean CD4 on presentation was 481 (range 35–1558); 60 (63.8%) had an undetectable VL at baseline. 30 (32%) had ED symptoms for >5 years. Risk factors: smokers 35 (37.2%); peripheral neuropathy 8; diabetic 2; abnormal cholesterol 44 (47%); abnormal hormone profiles 4. Sildenafil was the first agent in 55 (59%) patients and tadalafil in 28 (30%). 18 were on “poppers” and were told to stop before starting PDE5i. Improvement was noted in 51 (54%) after the first agent and 68 (72%) after the final agent. 36 (38%) had PDE5i side effects. 39 (41%) was on PI based Antiretroviral therapy. None reported priapism.

Conclusion It is safe to treat patients on PI with PDE5i by starting with half of the lowest dose tablet. Treatment of ED improves the quality of life in HIV positive patients but care must be taken to avoid serious drug interaction and safer sex practices should be emphasised.

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POTENTIAL IMPACT OF UPDATED UK GUIDELINES FOR USE OF POST EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE IN A LONDON SEXUAL HEALTH SERVICE

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Background Updated UK guidelines for post exposure prophylaxis following sexual exposure (PEPSE) outline new thresholds for when PEPSE is recommended (R), considered (C) or not recommended (NR).

Aim/Objective We compared practice and outcomes according to 2006 and 2011 guidelines.

Methods Retrospective review of electronic patient records between 20 January 2011 and 7 November 2011. Information regarding presentation, recommendations and outcomes were collected. Risk estimates were compared with guidelines. Blood abnormalities were classified grades I-IV. Data were analysed using Microsoft Excel.

Results Of 325 requests to a London sexual health service, PEPSE was issued on 281 occasions to 268 patients. Gender: male n=258, female n=10, median age: 32 years, sexual orientation: men who have sex with men n=236, heterosexual n=25, not recorded n=7. Risk exposure: unprotected anal (n=263) and vaginal (n=26) intercourse. Source details: HIV+ n=112 (40%), on antiretroviral therapy n=31, viral load known 40 (14%) (<50 n=26, >50 n=14). 71 (26%) reported taking PEPSE \geq once (range 1–5) previously. 99% commenced PEPSE within 72 h (median 30). Comparing those classified as R (n=258) and C (n=21) according to 2006 guidelines, 27 (10%) were reclassified NR using 2011 guidelines. Completion of 28 days PEPSE was reported in 59% cases, 100% adherence in 87%. Eight stopped early due to side effects (n=4) or the source tested HIV- (n=4). 148/268 (55%) had \geq 1 blood abnormality, grade I-II (n=196) and grade III-IV (n=29). 1 patient developed acute interstitial nephritis. 196/268 (73%) underwent \geq 1 screen for sexually transmitted infections; chlamydia (n=27), gonorrhoea (n=17), syphilis (n=4) and hepatitis B (n=1). Of 243 due 4-month follow-up, 52% have tested HIV- (n=122) and HIV+ (n=4).

Conclusions We report high rates of repeat PEPSE, side effects/blood abnormalities and poor completion rates. Updated guidelines may result in a modest reduction in the use of PEPSE.

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POST-EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL ASSAULT

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Background HIV post-exposure prophylaxis (PEP) is recommended for survivors of sexual assault. Completion rates are often lower than for PEP prescribed in other settings, which may be related to psychological issues faced by survivors immediately after the assault and a lower threshold for prescribing.

Aims To study outcomes of survivors of sexual assault prescribed PEP (Truvada and Kaletra) at an inner city sexual assault referral centre (SARC).

Methods Forensic and follow-up notes were interrogated for data on clients prescribed PEP between 1 June 2010 and 31 May 2011.

Results Data were available on 54 clients; 46 were female. Median age was 25 (range 14–40 years). Ethnicity: White European 35/54, 11/54 Black African/Caribbean and 8/54 Asian. 48/54 initiated PEP at the SARC, 4 in A&E and 2 in sexual health and all within 72 h. Exposure: 37 RVI, 14 RAI, eight unknown. 20/54 had an additional risk: 11 multiple assailants, eight defloration and seven ano-genital trauma. The assailant HIV status was unknown in all cases, but 11 were assessed to be high risk. 16/54 of the clients had never tested for HIV, 14 had tested negative previously and 24 were not documented. All had PEP prescribed within BASHH guidelines (2006). 36/54 continued care at the SARC. 20/36 (56%) completed 28 days of PEP. Nine were lost to follow-up, four discontinued due to side effects (Grade 1–2 nausea and vomiting), One due to abnormal blood results (Grade 1 rise in ALT and creatinine), one chose to stop and one was not documented. None had their PEP modified. 13/36 had an HIV test at 3 months post-PEP and all were negative.

Conclusions This study shows that PEP was prescribed within national recommendations. Completion rates were comparable to a local tertiary sexual health/HIV clinic that followed-up patients prescribed PEP after occupational and sexual exposure (66%) but lower than the 2006 BASHH standards (75%). This suggests that survivors of sexual assault may require greater adherence support.

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A USER CENTRED APPROACH TO THE DESIGN OF P-OF-CARE AND SELF-TEST MOBILE PHONE DIAGNOSTICS FOR SEXUALLY TRANSMITTED INFECTIONS (STIS)

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Background Effective Sexually Transmitted Infection (STI) control is being challenged by inadequate access to prompt diagnosis and treatment for patients and relatively poor community STI surveillance. This work forms part of a larger eSTI² (Electronic Self-Testing Instrument for Sexually Transmitted Infections) consortium developing diagnostic devices for pathogen detection and integrating point-of-care tests with mobile technology.

Aim(s)/Objective(s) Harnessing the widespread mobile phone use, this research develops innovative eSTI² technologies for reducing STIs transmission and providing greater personal control of sexual health. The aim of this study is to develop a wireless web-based management system that links chlamydia self-test diagnostics to further patient care pathways.

Methods This research adopts a user centred approach to the development of a Human Technology Interface for self-managing STI diagnosis. The research methodology begins primarily with initial exploratory pilot studies to gather functional and user requirements regarding ethical and regulatory requirements of the Human Technology Interface. Iterative development of functional prototypes