Results Overall, 4134 patients were treated for GC with CTX + AZM (n=1185, 31.5%) or CTX + DOXY (2830, 68.5%), 406 (9.8%) of whom were retreated. Treatment regimen was not related to time to retreatment, even when controlling for risk factors associated with re-infection (adjusted HR 0.88, 95% CI 0.70 to 1.14); a sub analysis of patients who were retested for GC within 90 days of CTX treatment also found no difference in retreatment rates across treatment regimens. Other factors that independently increased the risk of retreatment included: being a man who has sex with men, aged <25 years, having a history of GC or chlamydia, and reporting >2 sex partners within the past 6 months at time of CTX treatment. Patients treated after Expedited Partner Therapy (EPT) became available were 30% less likely to be retreated regardless of whether the patient themselves received EPT.
Discussion/Conclusions Compared to CTX + DOXY, CTX + AZM did not provide enhanced efficacy in this population. EPT is associated with a reduction in retreatment rates in the population even among those who did not receive EPT themselves.

P57 TO TREAT OR NOT TO TREAT

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Background The BASHH guidelines recommend offering full STI screening and epidemiological treatment to sexual contacts of those with confirmed Chlamydia infection. However, many patients attend sexual health clinics reporting to be contacts of Chamydia, but unable to give details of the index case. The management of these unverified Chlamydia contacts is unclear. Most clinics pragmatically treat contacts during their first visit; however some clinics may choose to wait for results before treating. This study was aimed at establishing current practice of management of Chlamydia contacts both verified and unverified, in a large inner city GUM clinic.
Method Health care practitioners were requested to fill in a questionnaire when patients who reported to be contacts of *Chlamydia trachomatis* attended the clinic over a 6-month period.
Results 59 Questionnaires were returned. In 76% (45/59) of patients attending as contacts of Chlamydia, details of index case could not be verified. 62% of these patients were asymptomatic and 56% (25/45) treated on first visit. Subsequently 27% (12/45) had a positive Chlamydia test whereas 36% of Chlamydia tests were positive in the cases where details of index case could be verified. The difference the positive rates of verified and unverified Chlamydia contacts is not significant (p=0.51).
Conclusion Despite acknowledging that our numbers are small, a high percentage of unverified Chlamydia contacts had positive Chlamydia tests. Given this we recommend that all patients attending STI clinics reporting to be contacts must be treated at first visit to avoid complications, losses to follow-up and decrease patient anxiety.

P58 NUCLEI ACID AMPLIFICATION TESTS (NAAT) FOR *TRICHOMONAS VAGINALIS*: SHOULD THEY CHANGE WHO WE SCREEN FOR INFECTION

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Background UK national guidelines recommend screening for *Trichomonas vaginalis* (TV) in symptomatic women and men with persistent urethritis using culture +/− wet mount microscopy. Screening of asymptomatic patients is not recommended due to the low prevalence of infection and low sensitivity of available tests. TV NAAT has been shown to have high sensitivity (96.7%) and specificity (97.5%) with the potential to increase the detection rate of TV infections.
Objectives To determine an accurate prevalence of TV infection in a UK STI clinic using the TV NAAT and to characterise the risk factors associated with TV infection to inform an appropriate screening strategy.
Method Over a 6-week period, unselected patients presenting to the UK STI clinic with a new clinical episode were offered a TV NAAT test (Gen Probe transcription-mediated amplification) as part of their sexual health screen. A vaginal swab was taken from women, and men provided either a urethral swab or urine sample. Information on demographics and clinical presentation was collected on a paper proforma. All data analysis was performed using SPSS V.19.
Results 3546 patients were seen in the study period of whom 98.8% provided a sample for TV NAAT testing. The prevalence of TV infection was 21/1483, 1.4% (95% CI 0.9% to 2.2%) in male patients and 72/2020, 3.6% (95% CI 2.8% to 4.5%) in female patients. The rate of TV positivity was higher in Black Caribbean patients compared to Caucasian patients in both men (5.4% vs 0.1%, p<0.001) and women (9.0% vs 1.2%, p<0.001). There was no significant difference in TV positivity across the age groups. In comparison to culture, TV NAAT detected an additional 24% of infections in symptomatic women.
Discussion TV NAAT is a more sensitive test. The prevalence of TV in UK STI clinic population is still low compared to USA. Given the higher cost of NAAT, screening of all clinic patients is unlikely to be cost-effective but may be worth considering in high risk subgroups.

P59 IMPROVING MANAGEMENT OF PELVIC INFLAMMATORY DISEASE BY USING A SIMPLE TICK-BOX STICKER

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Background Pelvic Inflammatory Disease (PID) is a common condition with a reported 1:50 sexually active women in the UK developing it annually. An estimated 1:5 will consequently become infertile. Use of the 2011 BASHH guidelines provides an excellent tool in improving uniformity in treatment and advice provided.
Aim To assess improvement in care from two cohorts of patient's with PID attending a District General Hospital clinic, at two points, 3 years apart by introduction of a PID tick-box sticker.
Method Using a BASHH guideline based proforma, data were recorded and compared between 2 cohorts, the 1st from June to December 2008 (27pts), the 2nd from 2011 (25pts).
Results In 2011: STI detection was increased at 48%, from 37% previously, reflecting national trends. 88% received 2 weeks of metronidazole and doxycycline (12% had erythromycin due to risk of pregnancy). None had ceftriaxone as per local guidelines based on this and an additional audit, which revealed very low prevalence of infection with *Neisseria gonorrhoeae* in the local PID population. Improvements with the introduction of the sticker included number of pregnancy tests performed—80% up from 26% and documentation of provision of written information which rose from 3.7% to 88%. 60% saw the HA at their clinic visit compared to 44% in 2008. Partner notification rates were unaffected with 51.6% of male contacts screened with a STI detected in 44% as opposed to 67% in 2008 with a STI in 37%. *N gonorrhoeae* was not identified in any presenting woman, nor any screened contact in 2011 and in only one contact in 2008.
Conclusion Introduction of a simple measure such as a PID sticker can aid documentation and adherence to correct management. Striving to improve better partner notification with subsequent

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screening and treatment, should remain a priority. Of note, there were no Gonococcal infections detected in any of our 2011 cohort and this reflects the local prevalence.

P60 LOW SPERM COUNTS IN ASYMPTOMATIC AND SYMPTOMATIC NON-SPECIFIC URETHRITIS AND OTHER SEXUAL HEALTH CLINIC ATTENDEES

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Background Little is known about semen parameters among men attending Sexual Health clinics. The significance of asymptomatic non-specific urethritis is controversial.
Aims (1) To investigate whether there is a higher incidence of abnormalities in the semen of men with urethritis compared to controls. (2) To investigate whether asymptomatic urethritis has similar effects (if any) on semen to symptomatic urethritis.
Objective To conduct a case-control study of abnormalities in the semen of Sexual Health clinic attendees compared to General Practice controls.
Methods Rates of semen abnormalities were compared between the different groups (19 with symptomatic and 27 with asymptomatic NSU, seven with symptomatic non-NSU and 64 clinic controls) and between clinic attendees and 417 patients attending general practice for the first investigation of possible infertility.
Results 117 clinic volunteers were included in the study. They were shown to have statistically significantly worse total sperm counts ($p=0.002$), volume of semen ($p<0.001$) and percentage of abnormal forms ($p<0.04$) compared to 417 GP controls. Compared to the rest of the clinic volunteers, asymptomatic NSU patients had statistically significantly lower total sperm counts ($p<0.02$). Asymptomatic NSU patients had statistically significantly lower total sperm counts compared to symptomatic NSU patients ($p<0.02$). Compared to GP controls, clinic controls had statistically significantly inferior total sperm counts ($p=0.009$) and semen volume ($p<0.001$).
Conclusions Sexual Health clinic attendees are more likely to have abnormalities of semen than patients attending general practice for a first check for possible infertility. A high rate of abnormal semen findings are found in patients with and without NSU but the highest rate occurred in those with asymptomatic NSU. Is asymptomatic NSU therefore pathogenic and does it require treatment like symptomatic NSU?

P61 IM CEFTRIAXONE FOR ALL PELVIC INFLAMMATORY DISEASE: TO GIVE OR NOT TO GIVE?

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Aim To audit the care of Pelvic Inflammatory Disease (PID) in a city centre Genitourinary medicine clinic.
Objectives (1) To assess the effectiveness of PID treatment offered by evaluating the auditable outcomes recommended within BASHH treatment guidelines. (2) To ascertain the level of detected infection with *Neisseria gonorrhoeae* in order to decide whether to implement IM ceftriaxone 500 mg stat as part of all PID treatment as per latest BASHH 2011 treatment guidelines.
Method A retrospective review of patient case notes coded with B4/B5, C4A and C5 from June 2010 till December 2010. A proforma was formulated and results then analysed using SPSS.
Results A total of 87 case notes were analysed. 100% of the patients were offered microbiological investigations (target—>95%) and 87.4% of the patients were treated with recommended regimens (target—>95%). 89.7% of the patients were referred for contact tracing (target—>95%) and the ratio of number of contacts screened/treated was 0.21 (target 0.4).
Discussion Only one audit outcome (>95%—microbiological investigations) was achieved. Gonococcal PID was confirmed on microbiological testing in only 2/87 patients (2.3%).
Conclusion We propose the introduction of a PID proforma to ensure greater uniformity of management and improve auditable outcomes. A local PID clinical guideline was adopted advising treating those at low risk of gonoccocal infection and mild to moderate PID with doxycycline plus metronidazole; and to add in IM ceftriaxone 500 mg stat to those with moderate to severe PID and/or those at high risk of gonoccocal disease. Re-audit will be conducted after the introduction of these measures.

P62 MANAGING THE CARDIOVASCULAR COMPLICATIONS OF LATE SYPHILIS

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Background BASHH recommends full clinical examination and chest radiography (CXR) for patients with late syphilis. Steroid cover and cardiology referral are advised for cardiovascular involvement. Recent literature suggests variation in the clinical management of suspected cardiovascular syphilis.
Aim To explore variations in the management of late syphilis in UK GUM clinics and to compare this with current BASHH guidelines.
Method Lead clinicians of UK GUM clinics were invited to complete an electronic survey between November and December 2010 to establish management of late syphilis in their centre. Data collected using the online Survey Monkey system were analysed with Microsoft Excel and SPSS V.18.
Results In total, 34% (53/156) of clinicians approached responded fully or partially to the survey (93% were consultants). An average of nine cases (n=45, SD 10.8) of late syphilis (KC60 codes A4, A5, A6) per clinic were seen between November 2009 and November 2010. Of these, 76% (n=42, range 0–100%) were estimated to have had a full clinical examination (and the use of CXR is described in abstract P62 table 1). *Other includes: older patients; HIV+ve patients; those with higher RPR; clinician dependent An ECG or ECHO was ordered routinely, or if the patient has symptoms or signs of cardiovascular syphilis, in 90% and 76% respectively. Cardiology referral was routinely made by 58% (18/31) and 35% (9/26) always used steroids, when managing cardiovascular syphilis.
Discussion Management of late syphilis varies both between clinics and compared with BASHH guidelines. Not all patients are examined or offered a CXR, and in cases with suspected cardiovascular involvement, cardiology referral and use of steroids are variable. Conversely, many patients are over-investigated in the GUM clinic.

Abstract P62 Table 1

Q: Under which circumstances is a CXR requested?	Routinely performed	If patient symptomatic	If patient has clinical signs	If routine, symptoms or signs	Other*
Mean % (no of respondents) n=44	48% (21)	41% (18)	36% (16)	89% (39)	25% (11)

*Other includes: older patients; HIV+ve patients; those with higher RPR; clinician dependent.

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