

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 gonococcal 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 gonococcal 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.