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**GENITOURINARY MEDICINE PHYSICIANS NEED FURTHER TRAINING IN THE MANAGEMENT OF HSV IN LATE PREGNANCY**

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<sup>1</sup>C Fleury,\* <sup>2</sup>E Clarke, <sup>1</sup>A Baker, <sup>3</sup>J Green, <sup>2</sup>E Foley, <sup>4</sup>R Patel. <sup>1</sup>University of Southampton, Southampton, UK; <sup>2</sup>Royal South Hants Hospital, Solent NHS Trust, Southampton, UK; <sup>3</sup>St. Mary's Hospital, Madison, Wisconsin, USA; <sup>4</sup>University of Southampton & Royal South Hants Hospital, Southampton, UK

**Background** Transmission rates of neonatal herpes simplex virus (HSV) infection varies from 30% to 50% if shedding with primary infection during the third trimester of pregnancy, to <3% with active recurrent genital infection. Despite the low transmission risk of recurrent HSV in pregnancy, there remains confusion regarding appropriate management.

**Aim** To investigate the level of knowledge of BASHH guidelines regarding the management of GH in the third trimester of pregnancy amongst BASHH conference attendees.

**Methods** Attendees of two BASHH conferences completed a questionnaire consisting of case-scenarios regarding appropriate management of pregnant women and their partners with genital herpes infection. The first case-scenario was designed to assess familiarity with accepted guidance. The second was used to assess whether physicians followed RCOG or BASHH guidelines.

**Results** 94 attendees completed the survey. In line with current guidelines, 81 (74%) answered that primary HSV infection at term was an indication for Caesarian section (CS), and 37 (46%) of these 81 responders stated this CS should be carried out at 38 weeks gestation. Of these 37 responders, when questioned concerning recurrent genital infection at term, 27 (73%) believed that lesions present at delivery would necessitate a CS, and 35 (95%) felt that vaginal delivery was appropriate in the absence of lesions at delivery. Although there is specific guidance for the limited place of invasive techniques at term only 17% would advise avoidance of fetal scalp electrodes and artificial membrane rupture.

**Conclusion** No-one demonstrated complete familiarity with the BASHH guidelines surrounding appropriate management of HSV. Of most concern is the limited awareness of the management need of CS in third trimester first episode disease. Further training of GUM physicians is required in order to ensure practice is compatible with the best available advice.

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**POINT (YOUNG PERSON'S) CLINIC AUDIT**

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<sup>1</sup>S Y Chan,\* <sup>2</sup>J Zhou, <sup>2</sup>S Rashbrook, <sup>2</sup>B Dragovic. <sup>1</sup>St Georges Healthcare NHS Trust, London, UK; <sup>2</sup>Queen Mary's Hospital, London, UK

**Background** Young people attending sexual health clinics should receive an adequate standard of care, according to BASHH clinical effectiveness group guidance.

**Aims/Objectives** To carry out an audit of clients attending the Point clinic—a sexual health clinic for clients aged ≤18. To describe client characteristics and compare practice against BASHH guidelines.

**Methods** We carried out a retrospective case notes review of all clients attending the Point clinic from 1 November 2009 to 30 April 2010. Patients were only counted once (new/rebook). Only patients having sexually transmitted infection (STI) screens were included. Information was collected on demographics, risk assessment, STI screening, HIV testing and contraception.

**Results** 123 clients attended. 51 did not have a screen. Reasons were: not sexually active, requesting contraception/condoms only, attending for results. Included in the audit were 72 patients who had STI screens. 53 out of 72 (73.6%) were female with a mean age

of 16.9. 10 out of 72 (13.9%) were <16. Fraser competence was assessed in all <16 years old. Risk assessment (age of partner/alcohol/drugs use/housing/mental health issues) was documented in 63/72 (87.5%) and in all <16 year olds. Contraception was reviewed in 64/72 (88.9%). Additional contraception advice was given to 36/72 (50%). Of the 34 not given additional contraceptive advice, six were not using any contraception. HIV test was offered to 71/72 and 35 accepted. 11/72 (15.3%) had an STI, most common being *Chlamydia trachomatis* (6/11).

**Conclusion** We are managing patients in accordance with BASHH guidelines. All <16 year olds (and those 16–18 where indicated) had a risk assessment completed. Offer of HIV tests was very good. It was identified that improvements were required with regards to provision of additional contraceptive advice.

**Women and children**

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**WHAT DO PHASE 1 MICROBICIDE TRIAL PARTICIPANTS REALLY THINK? ARE THEY "ONLY IN IT FOR THE MONEY?"**

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<sup>1</sup>G Morris,\* <sup>2</sup>S Douglas, <sup>1</sup>S Woodhall, <sup>1</sup>C Lacey. <sup>1</sup>Hull-York Medical School, York, UK; <sup>2</sup>York Hospital, York, UK

**Background** Early-phase trials require multiple visits and procedures, which can lead to difficulties with recruitment and compliance.

**Aims** To explore participants' experience of, and motivation for, taking part in a study of the safety and pharmacokinetics of an HIV microbicide.

**Methods** 28 women completed eight study visits including pelvic examinations, colposcopy, vaginal sampling (clinician performed and self-taken aspirate) and semi-structured, qualitative interviews. Additional requirements included daily vaginal gel use (12 doses) and sexual abstinence (16 days). Interviews were audio-recorded, transcribed, and analysed using a framework approach.

**Results** Although remuneration was given by 64% of women as the main or a contributing reason for participating, 71% also stated that they had an interest in HIV or saw the value in the research. 46% volunteered after hearing positive reports from other participants. Difficulties included speculum examinations, sampling, and fitting study visits and gel use into a normal routine. Problems with self-sampling were identified by 12 women, including discomfort and concern about obtaining an adequate sample. 10 participants reported a preference for self-sampling, 11 for clinician sampling. Compliance with gel use was high. Leakage was common but varied with position and depth of insertion. Four women found abstinence difficult. Being single, or discussing the study with partners before enrolment made abstinence easier.

**Conclusion** Qualitative interviews in early-phase trials capture useful additional information and help determine acceptability of procedures and products. Healthy subjects commonly have multiple non-exclusive reasons for participating in research. Understanding participants' motivation and experiences can aid recruitment and facilitate compliance with study requirements.

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**REVIEW OF THE FIRST ATTENDANCES IN UNDER-16 YEAR OLDS IN A COMMUNITY BASED INTEGRATED SEXUAL HEALTH SERVICE**

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N Pal,\* J Ashby. Berkshire Healthcare Foundation Trust, Bracknell, UK

**Aim** To analyse sexual and risk behaviour in under 16 year olds newly attending our services.