Results  Of the planned 1400 MSM, 99 (53 HIV+) have been recruited. Two equivocal results were excluded from analysis. Some of the questionnaire data were missing, 80% (75/91) were symptomatic and 60% (57/96) reported unprotected anal sex in the last month. The prevalence of CT and/or NG infection was 35% (95% CI 26% to 45%), CT alone 14% (95% CI 8% to 23%) and NG alone 21% (95% CI 13% to 30%). The sensitivity and specificity of PS vs SOC to detect CT/NG was 88% (95% CI 72% to 96%) and 100% (95% CI 93% to 100%), respectively (abstract P98 table 1). PS failed to detect four NG cases (3 pharynx, 1 rectum). MSM reported confidence (n=74, 86%) and willingness (n=75, 88%) to take their own samples (see abstract P98 table 1).

Abstract P98 Table 1  Sensitivity and specificity of pooled samples according to test

<table>
<thead>
<tr>
<th></th>
<th>Number positive (%) SOC testing [95% CI]</th>
<th>Number positive (%) PS testing</th>
<th>Sensitivity % [95% CI]</th>
<th>Specificity % [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT or NG*</td>
<td>34 (35) [26 to 45]</td>
<td>30 (88) [72 to 96]</td>
<td>100 [93 to 100]</td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>14 (14) [8 to 23]</td>
<td>14 (100) [73 to 100]</td>
<td>100 [95 to 100]</td>
<td></td>
</tr>
<tr>
<td>NG</td>
<td>20 (21) [13 to 30]</td>
<td>16 (80) [56 to 93]</td>
<td>100 [94 to 100]</td>
<td></td>
</tr>
</tbody>
</table>

Discussion  Pooled specimens in MSM offers the potential for significant savings and improved access to testing. Missed infections may be due to sampling error or low organism load. The evaluation of this strategy continues.

Conclusion  Gonorrhoea is concentrated amongst specific population sub-groups. Our analysis indicates that these groups are at high risk of contracting and transmitting other STIs as well as HIV, and underlines the need for targeted interventions.

P100  ASSESSMENT OF BACTERIAL SEXUALLY TRANSMITTED INFECTION (STI) SCREENING FOLLOWING SEXUAL ASSAULT  doi:10.1136/sextrans-2012-050601c.100

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Background  Chlamydia trachomatis and Neisseria gonorrhoea screening following sexual assault is undertaken primarily for sexual health purposes but can potentially facilitate criminal investigation in cases of penetration at sexually naive sites. Antibiotic prophylaxis at first attendance (within 7 days of the assault) is not routine but may be given when the return for screening is unlikely.

Aim  To improve bacterial STI screening and management in complainers attending our sexual assault referral centre (SARC).

Objectives  To determine if complainers were adequately screened for bacterial STIs and if communication with health professionals regarding repeat screening was adequate. To review prophylactic antibiotic use. To review the forensic significance of STI screening. To identify factors which may improve the uptake of screening.

Methods  100 case records were reviewed and information relevant to our objectives extracted. Six cases were excluded.

Results  81% had a STI screen taken at presentation. Only 13% returned for repeat screen after incubation, confirming Chlamydia in two cases. All but one repeat screen correlated to the site of exposure. GPs were informed of the need for a repeat screen in 74% of cases. 59% had an alert sited on their sexual health record highlighting the need for a repeat screen. Antibiotic prophylaxis was given in 25 cases with reasons documented in only 4.

Discussion and/or Conclusion  STI screening post sexual assault may be improved through better communication with complainers and other healthcare providers. Improvements to communication methods and training are required to facilitate this. The concern of emerging gonococcal resistance should be considered prior to administering prophylactic antibiotics. One individual, in whom there was no previous sexual contact and baseline screen was negative, had Chlamydia on repeat sample. This may be supportive of the assailant as the source of infection, indicative of the potential forensic role of STI screening.


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Background  It was feared that construction of venues for the 2012 Olympic and Paralympics Games would increase the burden of sexual ill-health in East London, due to a surge in migrant construction workers and commercial sex work.

Aims/Objectives  We analysed data from outreach to construction workers. We also reported demographics, sexual risk factors and STI rates.

Methods  An outreach team visited the Olympic site between February 2009 and October 2011. Clients completed a triage form about symptoms and sexual risk factors. Clients were offered nucleic acid amplification tests for Gonorrhoea and Chlamydia, using urine samples from men, and self-taken vulvovaginal swabs.