relatively costly to manage. BASHH guidelines acknowledge that the evidence base for recommendations is poor. We aimed to describe the management regimes of GUM Consultants who routinely manage these conditions within our large network prior to introducing sector-wide guidelines.

**Method** We emailed appropriate GUM consultants from the six network centres requesting their standard management regimes for both conditions. We collated the responses and used BASHH Guidelines as a standard for comparison.

**Results** All 14 consultants responded. Treatment regimes for VVC were broadly similar but only three consultants prescribed according to BASHH Guidelines. 13 consultants prescribed induction regimes. All consultants used oral fluconazole, doses included 50, 100 and 150 mg. Duration of induction regimes ranged from 3 daily doses, alternate day doses, 72 h doses to daily dose for 14 days. Ten consultants prescribed maintenance therapy for 6 months, 4 stopped after 3 months. 11 consultants prescribed 150 mg weekly for at least 3 months. For recurrent BV there was considerable variation and no one followed BASHH guidelines. Regimes included oral metronidazole (2 g, 400 mg), metronidazole gel or clindamycin pessaries. Induction ranged from 5 to 14 days, maintenance from 3 to 6 months. All consultants prescribed menstrual regimes if appropriate. Three consultants also prescribed Balance Activ or equivalent.

**Conclusion** Management of recurrent BV and VVC varied greatly across the network. Management of recurrent VVC was more closely associated with BASHH guidelines than management of recurrent BV. Management regimes are often based on clinicians’ own experience. New network guidance has now been established providing a local standard for future case record audit.

**IS IT USEFUL TO PERFORM A FULL PHYSICAL EXAMINATION IN ASYMPTOMATIC PATIENTS WITH LATE SYPHILIS?**

R Dabis,* K Radcliffe. University of Birmingham, Birmingham, UK

**Background** In late and congenital syphilis a thorough physical examination should be undertaken for signs of syphilis as per British Association for Sexual Health and HIV guidelines. This should include examination of skin and mucosal surfaces, lymph nodes, the cardiovascular and neurological systems.

**Aims** To audit all cases of late syphilis at our centre to see if a full cardiovascular and neurological examination was documented and also to see if a full examination contributed to the management of asymptomatic patients.

**Methods** A total of 648 notes were identified as late syphilis from KC60 codes from our local database. Records were from the period 1994 to 2010. The following information was extracted from the clinical records: age, ethnicity, gender, sexuality, symptomatic/asymptomatic, cardiovascular and neurological examination findings and further action taken where applicable. 148 notes were unavailable. 20 notes were excluded. Therefore 480 notes in total were audited.

**Results** Of the 480 patients, 262 (55%) were of Black Caribbean ethnicity, 75 (16%) White British, 68 (14%) Black African and 75 (16%) others. 240 (50%) were heterosexual males, 206 (43%) heterosexual females, 51 (6%) men who have sex with men. Information on sexual orientation was not available in 3 (1%). 295 patients were asymptomatic of which 238 (98%) had normal physical examinations. Seven asymptomatic patients had positive clinical findings but these did not lead to a diagnosis of cardiovascular or neurological syphilis. In 99 cases a full examination was not documented and in 21 cases patients declined or defaulted further follow-up. There were 65 symptomatic patients all had abnormal physical findings.

**Conclusion** In view of the absence of significant clinical examination findings in patients with late syphilis we believe that a physical examination is not a necessary element in the management of such cases and should be omitted.