primary care. In view of the wide variation in positivity by locality, it is likely testing for TV will be cost effective in some areas. Ongoing surveillance may be necessary to identify those at risk.

O30 SERVICE PROVISION AND ECONOMIC IMPLICATIONS OF IMPLEMENTING NAAT TESTS FOR *TRICHOMONAS VAGINALIS* IN WOMEN ATTENDING GENITOURINARY MEDICINE CLINICS AND PRIMARY CARE

[1]Katy Turner*, [2]Jane Nicholls, [3]Peter Muir, [1]Margaret May, [2]Paul North, [1]John Macleod, [1]Paddy Horner. *[1]University of Bristol, Bristol, UK; [2]Bristol Sexual Health Clinic, Bristol, UK; [3]Public Health England, Bristol, UK*

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Background/introduction Laboratory tests for *Trichomonas vaginalis* using culture and microscopy in current practice have low sensitivity, however new, highly sensitive PCR-based nucleic acid amplification tests (TV NAATs) have been approved e.g. Aptima TV NAAT. It is not known how to optimally deploy these new tests in different settings.
Aim(s)/objectives To assess the cost-effectiveness of new TV NAAT tests for the diagnosis of TV infection in women attending genitourinary medicine (GUM) and primary care clinics. To inform national decision-making about who should be offered TV testing.
Methods We analysed data from TV tests in residual chlamydia/gonorrhoea samples from nearly 9,000 women. We conducted notes review in GUM clinics to understand current practice. We compared current and proposed pathways for management of TV. We calculated the cost of testing for TV in GUM and primary care.
Results Table 1 shows the breakdown of test results by symptomatic/asymptomatic and setting and indicates the current and new cost of testing. (NB. Provisional data, study closed 31/1/2015). Compared with current testing practice, TV NAAT testing detected an additional 41 cases from GUM. In primary care few samples were sent for laboratory testing; only 15 out of 126 NAAT positive cases would have been detected.
Discussion/conclusion TV NAAT tests detected many more infections than current testing. Nationally, this translates to an increase in GUM from 6,000 cases to 23,400 cases annually. Overall, the crude cost of adding TV NAAT testing to all chlamydia and gonorrhoea tests is £307 per additional infection diagnosed.

O31 MENSES – TO TEST OR NOT TO TEST?

[1]Sarah Schoeman*, [2]Catherine Stewart, [1]Janet Wilson. *[1]Leeds Teaching Hospitals Trust, Leeds, UK; [2]Salford Royal Foundation Trust, Manchester, UK*

10.1136/sextrans-2015-052126.31

Background/introduction Varied advice is given to women about testing for chlamydia (CT) and gonorrhoea (NG) whilst menstruating. Some are advised it makes no difference, others are advised not to test or are offered urine sampling instead of a vulvovaginal swab. There is no published evidence to inform such advice.
Aim(s)/objectives To determine if menses affects the performance of CT/NG NAATs.
Methods Using data collected in a large CT/NG NAATs diagnostic study we compared the prevalence of infections in menstruating women versus those not menstruating.
Results Of the 3973 study participants 162 (4%) were menstruating and 3811 were not. 30 (18.5%) menstruating women had CT and 10 (6.2%) had NG; 380 (10%) non-menstruating women had CT and 90 (2.4%) had NG. Menstruating women were more likely to be diagnosed with CT (OR 2.05; p = 0.0008) and NG (OR 2.72; p = 0.0055); less likely to have had a previous STI (OR 0.66) and to have cervicitis (OR 0.21) but more likely to be a STI contact (OR 2.13) and have bacterial STI symptoms (OR 1.36). After adjusting for these confounding variables menstruating women remained more likely to be diagnosed with CT (Adjusted OR 1.98; 95% CI 1.27–3.09; p = 0.003).
Discussion/conclusion Menses does not have a negative effect of the performance of CT/NG NAATs; in fact the prevalence of infections was higher in menstruating women. Only 4% of women were menstruating suggesting that women avoid attending for STI testing during their period unless really necessary. Hence testing should be performed during menstruation using vulvovaginal or endocervical swabs.

O32 ASYMPTOMATIC NEUROSYPHILIS IS UNLIKELY IN HIV INFECTED PATIENTS AFTER TREATMENT FOR EARLY SYPHILIS WITH BENZATHINE PENICILLIN G

Andrew Tomkins*, Shazaad Ahmad, Darren E Cousins, Francisco Javier Vilar, Stephen P Higgins. *North Manchester General Hospital, Manchester, UK*

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Background/introduction Benzathine penicillin G (BPG) does not cross the blood-brain barrier. Some experts believe that BPG may be ineffective when treating patients co-infected with HIV and syphilis.
Aim(s)/objectives To establish the risk of asymptomatic neurosyphilis (ANS) after treatment of early syphilis in HIV positive patients with single dose BPG.
Methods HIV patients with early syphilis were offered a post-treatment lumbar puncture if their CD4 count was <350 and/or their serum RPR >16. Patients with clinical neurosyphilis were excluded. ANS was defined as a positive CSF RPR, or CSF white blood cells >20/mm^3 plus CSF TPPA >1:320.

Abstract O30 Table 1 *Trichomonas vaginalis* test results in symptomatic and asymptomatic women in GUM and primary care

		Positive (current)	Negative	Total (current)	Positivity	Current cost	New cost	Cost per extra case
Genitourinary medicine	Symptomatic	22 (9)	497	519 (440)	4.2%	£3,489	£3,955	£35.8
	Asymptomatic	28 (0)	1571	1599 (0)	1.8%	£0	£12,184	£435.2
Primary care	Symptomatic	86 (13)	3185	3271 (1651)	2.6%	£13,092	£24,925	£162.1
	Asymptomatic	40 (2)	3405	3445 (497)	1.2%	£3,941	£26,251	£587.1
Total		**176 (24)**	**8658**	**8834 (2588)**	**2.0%**	**£20,523**	**£67,315**	**£307.8**

Results 64 patients participated (median CD4 417/mm^3, range 84–1100). 50 of the patients were treated with single dose BPG. Only one patient had ANS (prevalence 1.56% 95 CI 0.04–8.4) with CSF RPR negative, CSF TPPA 1:1280 and lymphocytes 45/mm^3. Two patients had a pleocytosis (50 and 22 white cells/mm^3 respectively) with negative CSF RPR and CSF TPPA and thus did not meet diagnostic criteria for ANS per protocol.
Discussion/conclusion Our study suggests that single dose BPG is effective treatment for early syphilis in HIV co-infected patients. We will present more data to support this conclusion.

O33 AEROBIC VAGINITIS: PREVALENCE, MANAGEMENT AND OUTCOMES IN A LARGE INTEGRATED SEXUAL HEALTH CLINIC

[1]Mark Mason*, [2]Bethan Little, [1]Andrew Winter. *[1]Sandyford Sexual Health Services, NHS Greater Glasgow & Clyde, Glasgow, UK; [2]University of Glasgow School of Medicine, Glasgow, UK*

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Background/introduction Aerobic vaginitis (AV), a syndrome of abnormal vaginal microflora, was first described in 2002 and is increasingly recognised as a condition distinct from bacterial vaginosis that may require different management.
Aim(s)/objectives To describe the prevalence of moderate-to-severe AV, its management and outcomes in a UK setting.
Methods We included all women presenting to our large integrated sexual health service who met criteria for gynaecological examination and near-patient microscopy. A single biomedical scientist scored the wet mount according to the method of Donders *et al*. If the score was 5 or above (indicating moderate to severe AV) the requesting clinician was informed. We reviewed case notes to determine treatment choice and outcome.
Results From 1/12/13 to 30/11/14, 1616 wet films were read. Overall, 314 (19.4%) had an abnormal AV score (11 (0.7%) severe AV (score >6), 61 (3.8%) moderate AV (score = 5–6), 253 (15.7%) slight AV (score = 3–4)). Patients with severe AV were significantly older than those with moderate AV (mean age 42.7 vs 32.0 years, p = 0.04), but only 6 (8.3%) patients had atrophic change. Among patients with AV scores of 5 or more, trichomonas was seen in 2 (2.8%) patients, 13 (18.5%) had evidence of yeast infection. First-line treatment included intravaginal clindamycin (49.7%), oral metronidazole (27.3%), antifungals, penicillins, acidification gel and local oestrogen. Symptoms persisted in 19.4%, re-occured in 4.2% and resolved in 43%, with 33% not re-attending.
Discussion/conclusion Patients with moderate-to-severe AV scores are challenging to manage with a high proportion of repeat attendance. Severe AV occurs in an older population.

Clinical Case Studies: 2nd June 2015

C1 CASE SERIES: MANAGING DESQUAMATIVE INFLAMMATORY VAGINITIS IN TRANS-MEN

Kate Nambiar*, Deborah Williams, Tamara Woodroffe, Alison Parnell, Daniel Richardson. *Brighton and Sussex University Hospitals NHS Trust, Brighton, UK*

10.1136/sextrans-2015-052126.34

Background/introduction Desquamative inflammatory vaginitis (DIV) is an uncommon condition characterised by florid vaginal inflammation causing vaginal discharge, vulval pain and dyspareunia. Microscopy typically shows absent vaginal flora, numerous polymorphs and immature parabasal cells with no mature epithelia. The pathogenesis of DIV is currently unknown but may involve tissue kallikrein-related peptidases which are regulated by sex hormones and corticosteroids.

Case-1: 35-year-old trans-man on testosterone for 18-months presenting with yellow vaginal discharge, vestibular pain and dyspareunia. Examination revealed vaginal inflammation and mucopurulent discharge. Microscopy was typical of DIV. He was treated with intravaginal clindamycin reporting a good response.

Case-2: 26-year-old trans-man on testosterone for 7-years presenting with vaginal discharge, dyspareunia and post-coital bleeding. Examination revealed inflamed friable vaginal mucosa. Microscopy findings were typical of DIV and he started treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

Case 3: 20-year-old trans-man with vaginal discharge and post-coital bleeding who started testosterone 6-months earlier. Examination and microscopy findings were typical of DIV. He commenced treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

Case 4: 19-year-old trans-man on testosterone for 9-months presenting with vaginal pain and bleeding. Examination and microscopy were typical of DIV. He started treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.
Discussion We present four cases of DIV in trans-men possibly associated with androgens responding to intravaginal clindamycin and steroids. As well as causing significant morbidity DIV may increase transmission of sexually-transmitted-infections in trans-men: we need to understand more about its aetiology, management and long term outcomes.

C2 GONOCOCCAL TENOSYNOVITIS IN TWO HIV-INFECTED HETEROSEXUAL MALES: DELAYED DIAGNOSES FOLLOWING NEGATIVE URINE NAAT TESTING

Jonathan Shaw*, Peter Flegg, John Sweeney. *Blackpool Sexual Health Services, Blackpool, UK*

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Background Disproportionately high gonococcal incidence rates amongst men have altered the clinical picture of disseminated gonococcal infection (DGI). The 'classical' female patient experiencing a triad of arthritis, tenosynovitis and cutaneous lesions no longer predominates. We present two cases emphasising the need for thorough investigation with evident clinical signs of DGI.
Cases A 48 year old Nigerian heterosexual male presented with a 6 cm inguinal mass and oral hairy leukoplakia. Impression was of lymph node abscess; HIV testing was positive. Urine Nucleic Acid Amplification Testing (NAAT) for chlamydia and gonorrhoea (CT/GC) was negative. Subsequently he developed a swollen tender left wrist. Inguinal abscess aspiration for NAAT testing returned a positive gonococcal result. Treatment was instigated with intravenous ceftriaxone for 4 days, subsequently switching to cefixime for a further week. 3 weeks later his wrist swelling resolved.