Background GC is the second most common sexually transmitted infections after chlamydia. The emergence of resistant strains has made it vital for each case to be managed according to national standards in order to reduce onward transmission.

Aim To compare the current management of GC across five centres in Essex in accordance with the British Association of Sexual Health and HIV (BASHH) auditable outcomes.

Methods 30 case notes of confirmed GC diagnosis from each centre between January–September 2013 were reviewed. Data collected included demographic, sites of infection, diagnostic methods, chlamydia testing, treatment protocol, test of cure (TOC), partner notification (PN) and health adviser (HA) referral.

Results As illustrated in Table 1. 150 cases were analysed. Most infections were acquired locally, diagnosed clinically alongside microscopy with majority isolated from the urethra in male and cervix in female. 3 resistant strains were identified. Multiple sites of infection were also observed. 143 (95.0%) cases were managed in accordance with all treatment and diagnostic standards but only 84.6% had TOC, 83.8% PN and 67.7% seen a HA.

Conclusion Almost all GC cases in the region were well managed. However TOC, PN and HA referral standards were not met likely due to lack of resources and poor documentation.

Background Monitoring trends in chlamydia-related sequelae, such as epididymitis and pelvic inflammatory disease (PID), is an important aspect of the evaluation of chlamydia control initiatives such as the National Chlamydia Screening Programme (NCSP). Unlike PID, which can be difficult to diagnose, epididymitis may be a useful measure for evaluation purposes. The objective of this analysis was to examine trends in epididymitis diagnosis rates in the era of increased chlamydia testing.

Methods Diagnoses of epididymitis among 15–35 year old males were obtained from the genitourinary medicine (GUM) clinic activity dataset version 2. Diagnosis rates were calculated, per year, using the number of new-episode male clinic attendees. This accounted for changes in clinic attendance over the years. Negative binomial regression was used to derive the incidence rate ratios (IRR) and test significance of the trends.

Results Between 2009 and 2013, a total of 24,689 diagnoses of epididymitis were made among 15–35 year old males, of which 10% (2,506) were of chlamydial and 2% (473) of gonococcal origin. Diagnosis rates of chlamydial epididymitis declined by an average of 12% per year (IRR = 0.88, 95% CI; 0.81–0.96, p < 0.001), while no statistically significant changes were observed in rates of gonococcal epididymitis (IRR = 0.93, 95% CI; 0.86–1.00 p = 0.276). A small but significant decline of 2% per year (IRR 0.98: 95% CI; 0.96–0.99, p = 0.001) was observed for rates of non-specific epididymitis.

Conclusion The decreased rate of chlamydial epididymitis diagnoses in men may be associated with increased chlamydia testing, however, the influence of other contributing factors should be explored.