ventricular dysfunction, at a level requiring cardiac transplant. ECG showed prolonged QT interval. The patient was diagnosed with toxic dilated cardiomyopathy secondary to long term AM abuse. UK guidelines for Heart transplantation in adults deem chronic viral infection and ongoing substance misuse as relative contraindications to transplant. He was consequently commenced on medication for cardiac failure and received benzodiazepine as inpatient for managing withdrawal symptoms. On discharge, psychiatry follow-up was organised for support to help reduction of AM. At follow up, the patient reported reduced AM use by quarter, but felt he could never abstain.

**Discussion/conclusion** AM related cardiac fatalities are caused by acute myocardial necrosis, ventricular rupture, cardiomyopathy or arrhythmia. Evidence is mostly derived from case-reports. Patients using AM should be fully counselled regarding possible toxic effects.

### P50 NON-ISCHAEMIC DILATED CARDIOMYOPATHY IN HIV POSITIVE PATIENTS; A CASE SERIES

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10.1136/sextrans-2015-052126.94

**Background** HIV is a well-known cause of dilated cardiomyopathy, with an annual incidence of 15.9 per 1000 asymptomatic HIV patients in the pre-HAART era. Despite reduced incidence with HAART, it remains an important cause of cardiac morbidity in people with HIV though its direct association to the virus is unclear.

**Methods** Retrospective case review.

**Results** Four patients with dilated cardiomyopathy were identified out of 4739 attending between 2002–2014. Mean age was 49 years (range 38–62), all were male. Two presented as admissions with cardiac failure; two were diagnosed on routine investigation for exertional dyspnoea. All clinically improved with medical management; the three cases under long term follow up (6–10 years) showed improvement in ejection fraction (EF), though one died 10 years post diagnosis of presumed sudden-cardiac death.

**Discussion** This small case series highlights the positive outcomes with medical management of dilated cardiomyopathy in HIV. The direct role of HIV remains unclear; these cases reinforce the importance of regular screening for recreational drug use and consideration of their potential cardiotoxicity, and awareness of other aetiological factors.

## Category: Electronic patient records and use of information technology

### P51 THE UTILITY OF PERSONALISED SHORT MESSAGE SERVICE (SMS) TEXTS TO REMIND PATIENTS AT HIGHER RISK OF STIS AND HIV TO RE-ATTEND FOR TESTING

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**Background** Patients at increased risk of STI/HIV acquisition are advised to re-attend for re-testing. A previous study showed that 'generic' text reminders did not improve re-attendance.

**Aim** To assess if a personalised text message would increase re-attendance rates of at risk patients who require repeat STI testing.

**Methods** At-risk patients were sent a text reminder to re-attend for re-testing 6 weeks after their initial visit. They were considered to be 'at risk' if they had an acute STI or had attended for emergency contraception at the initial visit, or were MSM. Re-attendance rates were measured for September to December 2012 (control group who received a generic text message advising re-attendance) and February to May 2014 (personalised message group who received a text message containing their first name and several different ways to contact the clinic). Re-attendance was counted within four months of the end of the initial episode of care.

**Results** The re-attendance rate was significantly higher for the personalised message group (144/266(54%) than the control group: (90/273 (33%) (P = 0.0001) and was also significantly higher in the personalised message group than the control group in patients with the following risks: recent chlamydia (61/123 (50%) vs (43/121(36%) (P = 0.03), recent gonorrhoea (42/64 (66%) vs (4/21(19%) (P = 0.0003) and MSM (25/45(56%) vs (3/18(16%) (P = 0.006). New STI rates in the re-attending 'personalised message' group and controls were 26/144(18%) and 13/90 (14%) (n.s) respectively.

**Conclusion** Sending a personalised text message as a reminder for re-testing increases re-attendance rates in patients who are at higher risk of STIs.

### P52 KEEPING "APP" TO DATE: USING GEOLOCATION APPS TO SIGNPOST TO LOCAL SEXUAL HEALTH SERVICES

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**Background/introduction** To encourage HIV testing amongst men who have sex with men (MSM) during "National HIV testing week" (NHTW) point of care testing (POCT) was offered at community and hospital-based sexual health services (SHS). Users of the social networking application "Grindr" within 5 miles of our clinics received a link to our website, which was upgraded to include a video demonstrating HIV POCT. Traditional health promotion poster campaign was also employed.

**Aim(s)/objectives** To review advertising strategies used and clients who requested POCT during NHTW.

**Methods** Activity data was obtained from the software company and electronic records of those attending for POCT were reviewed.

**Results** 43 asymptomatic attendees requested POCT testing, 35 male and 8 female. 21 males identified as MSM (60%), 15 (71%) disclosed that they had attended as a result of the "Grindr" advertisement. The average MSM number of daily visits to the website increased from 250 to 600/ day, highest at weekends the majority via "Grindr". POCT video was viewed 126 times during testing week. 30 (70%) patients accepted a sexual health screen, 3 asymptomatic infections were diagnosed. No HIV diagnoses were made.

**Discussion/conclusion** Social networking proved popular amongst MSM. No HIV diagnoses were made however screening increased HIV testing and identified sexual infections in



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asymptomatic individuals (all signposted via "Grindr"). Current work includes using "Grindr" to signpost users to our service, implementing online booking and expanding the use of POCT at community SHS. Clinics should consider using social media and geolocation-based apps in addition to traditional health promotion.

## P53 WITHDRAWN

## P54 SYSTEMATIC REVIEW AND META-ANALYSIS OF RANDOMISED CONTROL TRIALS OF INTERACTIVE DIGITAL INTERVENTIONS FOR SEXUAL HEALTH PROMOTION

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10.1136/sextrans-2015-052126.97

**Background** Digital technology offers potential for sexual health promotion.

**Aims** We conducted systematic review examining effectiveness of sexual health promotion interactive digital interventions (IDI) compared to 1) minimal interventions (e.g. leaflet); 2) face-to-face interventions; 3) different IDI designs.

**Methods** IDI require users' contributions to produce personally relevant feedback. We searched 40 electronic databases for randomised controlled trials (RCT) of IDI for sexual health promotion from start dates to 30/04/2013. Separate meta-analyses were conducted for comparisons 1, 2, and 3, by outcome types (knowledge, self-efficacy, intention, sexual behaviour, biological outcomes) using random effects models. Subgroup analyses tested: age, risk grouping, setting (online, healthcare, educational).

**Results** We identified 36 RCTs (11,818 participants) from developed countries. Comparison 1: IDI improved knowledge ((standardised mean difference (SMD) 0.48, 95% CI 0.19 to 0.76)); self-efficacy (SMD 0.11, 95% CI 0.04 to 0.19), intention (SMD 0.13, 95% CI 0.05 to 0.22), sexual behaviour ((Odds Ratio (OR) 1.20, 95% CI 1.02 to 1.41)), but not biological outcomes (OR 0.81, 95% CI 0.56 to 1.16). IDI delivered in educational settings improved sexual behaviour (OR 2.09, 95% CI 1.43 to 3.04), but not in healthcare settings (OR 1.17, 95% CI 0.94 to 1.45), or online (OR 0.96, 95% CI 0.79 to 1.17). Comparison 2: IDI improved knowledge (SMD 0.36, 95% CI 0.13 to 0.58), intention (SMD 0.46, 95% CI 0.06 to 0.85), but not self-efficacy (SMD 0.38, 95% CI -0.01 to 0.77). Comparison 3: Tailoring had no effect on outcomes.

**Conclusion** IDIs can enhance knowledge, self-efficacy, intention, and sexual behaviour.

## P55 THE USE OF WEB-BASED TECHNOLOGY TO MEASURE PATIENT EXPERIENCE IN SEXUAL HEALTH SERVICES

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**Introduction** In comparison to other specialities, generating feedback from sexual health patients on clinic experience is challenging. Web-based technology can address many challenges associated with paper-based surveys, and is increasingly used to generate feedback in healthcare. A survey conducted in our service showed that four-fifths of our patients use smartphones; we therefore wanted to use technology to capture patient experience of our service.

**Aim** To measure real-time patient experience of our sexual health service using an online questionnaire.

**Methods** Since May 2014, new patients attending one of our five services are sent a link to an online survey via free text message. The short survey captures demographic data and feedback, with facility to request call back to discuss any concerns.

**Results** Since May 2014, 2457 new patients (18%) have completed the survey (2457/13753).

**Discussion** We have demonstrated high levels of satisfaction with our service as a result of this online survey. Implementation challenges include varying response rates, administration time and cessation of free messaging. However, the generation of real-time feedback is valued by staff, commissioners and patients, and has resulted in several service improvements e.g. improved signage and new processes for triaging patients.

**Abstract P55 Table 1** Patient survey results

| Clinic | Percentage responses | Male | Seen within 30 mins | Treated with dignity/respect (strongly agree/agree) | Would recommend service (strongly agree/agree) |
|---|---|---|---|---|---|
| C1 | (1090/7417) 15% | 48% | 49% | 97% | 94% |
| C2 | (493/2200) 22% | 35% | 24% | 93% | 90% |
| C3 | (255/1605) 16% | 52% | 46% | 95% | 92% |
| C4 | (276/1921) 14% | 38% | 22% | 96% | 88% |
| C5 | (343/610) 56% | 15% | 50% | 90% | 81% |

## P56 ELECTRONIC PATIENT RECORDS (EPR) AND THE IMPACT ON ATTENDANCE WITHIN A LEVEL 3 SEXUAL HEALTH SERVICE

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**Background** Staff complained that the introduction of the EPR in December 2013 slowed down their consultations and thought that attendances had reduced significantly as a result of having to "cap" walk in clinics and reduce the number of appointment slots. In the early months post implementation there were



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