Aims To collate and assess the existing literature on the role of and barriers to the GP providing shared care for PLWHIV.

Methods MEDLINE, PsycINFO and EMBASE were searched using MESH terms “HIV” or “AIDS” combined with “general practice” or “primary health care”. Empirical studies from developed countries relating to the role, involvement or barriers of GP utilisation in shared care were used. Eleven research articles were eligible for this review.

Results Most GPs and patients want to engage in shared care. 81.8–89% PLWHIV were registered with a GP and 78% had disclosed their status. Potential barriers included lack of specialist knowledge, accessibility, issues of confidentiality and stigmatisation, and poor communication between services. GP engagement was dependent on their experience with HIV, local prevalence of HIV and patient level of morbidity.

Conclusions This review demonstrated large variations between UK health service provisions for PLWHIV. Disclosure to GPs has improved in the post-HAART (highly active antiretrovirals) era; however remaining barriers to shared care, primarily communication between services, needs to be addressed. Further research to develop models of shared care for PLWHIV is necessary to provide comprehensive safe, good quality care.

### P125 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEAE

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10.1136/sextrans-2015-052126.168

Background Pelvic Inflammatory Disease (PID) describes a broad spectrum of disease primarily diagnosed clinically, with signs and symptoms lacking both specificity and sensitivity. Mycoplasma genitalium (MG) is becoming increasingly implicated in cases of non-chlamydial non-gonococcal PID. The core principle of the management of PID remains to maintain a low threshold for diagnosis and treatment to prevent long-term sequelae.

Aim To evaluate the current management of PID amongst sexual health physicians across Europe against the current European guidelines.

Methods A clinical scenario based questionnaire was developed by a panel of European experts on PID, and this was disseminated to a network of sexual health specialists who conduct questionnaire based research across the European region.

Results Provisional results demonstrate variation in practice across Europe and this is most marked in routine testing for and treatment of MG-associated PID, factors influencing the choice of antibiotic therapy, and action taken when an intrauterine device or system is in situ. Full results will be available by the conference.

Conclusion The management of PID varies across Europe and is not always in line with current European guidelines. There is a need for ongoing European wide education to ensure that patients are receiving evidence based care. Furthermore, there are issues

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<tbody>
<tr>
<td>1) All patients treated for GC should be recommended to have a test of cure (TOC)</td>
<td>91% (66% had a TOC)</td>
<td>91% (66% had a TOC)</td>
<td>84.6% (52.9% had a TOC)</td>
<td>91% (60% had a TOC)</td>
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<td>2) All patients with gonorrhoea should be screened for genital infection with Chlamydia trachomatis or receive presumptive treatment for this infection</td>
<td>100%</td>
<td>100%</td>
<td>98.6%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>3) All patients identified with gonorrhoea should have partner notification carried out according to the published standards of the BASHH Clinical Standards Unit</td>
<td>82%</td>
<td>95%</td>
<td>92%</td>
<td>92%</td>
<td>88%</td>
<td>90.4%</td>
<td>93%</td>
</tr>
<tr>
<td>4) All patients identified with gonorrhoea should be offered written advice about STIs and their prevention</td>
<td>32%</td>
<td>64%</td>
<td>81%</td>
<td>61%</td>
<td>50%</td>
<td>66%</td>
<td>27%</td>
</tr>
<tr>
<td>5) All patients with gonorrhoea should receive first-line treatment, or the reasons for not doing so should be documented</td>
<td>77%</td>
<td>96%</td>
<td>100%</td>
<td>97%</td>
<td>88%</td>
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<td>97%</td>
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in clinical practice which are currently not covered by the European guidelines and these need to be reviewed to provide physicians with appropriate guidance.

**P127** SPECIAL INTEREST CLINIC: A NOVEL GENITOURINARY MEDICINE SERVICE INITIATIVE PROVIDING CONTINUITY OF CARE AND EDUCATIONAL OPPORTUNITIES

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10.1136/sextrans-2015-052126.170

**Introduction** External referral to dermatology and psychosexual services from genitourinary medicine (GUM) can cause delays in patient care. To counter this within our service an experienced consultant has established a Special Interest Clinic (SIC) reviewing dermatology, erectile dysfunction and complex GUM cases. Written educational feedback is offered to internal referers. We reviewed the impact of SIC.

**Aims** To evaluate the service offered by SIC.

**Methods** Data was collated from randomly selected patient records who attended SIC between April 2012 and April 2013.

**Results** A total of 100 records were reviewed. 67 patients were male, 25 of whom were MSM. Patients were ethnically diverse, White British (52) being the most common ethnicity. Median age was 33 years (range 19–70). 12 patients were HIV-infected. Internal referrals predominated (96) and average waiting time from referral was 6.2 weeks (range 0.14–28). Broadly stratifying referrals 40 patients were complex GUM, 35 psychosexual medicine, 25 dermatology. The most prevalent diagnoses were erectile dysfunction (23) and lichen sclerosus (9). 9 patients required skin biopsy, 8 of which were performed within SIC. Ongoing follow up was recommended to 60 patients, of which 43 (71.7%) were retained. 27 patients were discharged after first attendance. 77 referrers requested feedback, all received it.

**Conclusion** Keeping patients within our service provided continuity of care. The availability of formal feedback increases educational opportunities for referrers. We recommend experienced clinicians consider establishing similar SICs in other services. A challenge services will encounter is the lack of specific SHHAPT coding for prevalent SIC diagnoses.

**P128** MEETING STANDARDS IN MANAGEMENT OF SEXUAL ASSAULT: ARE WE THERE YET?

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10.1136/sextrans-2015-052126.171

**Background/introduction** Effective management of victims of sexual assault is important to encourage people to report abuse and receive care. BASHH provide guidance on management of sexually assaulted patients. We reviewed case notes of 36 patients who were treated for sexual assault.

**Aim(s)/objectives**

- To identify demographic characteristics of sexually assaulted victims attending the clinic.
- To understand how we meet the BASHH guidance (2011) in the management of sexual assaults.
- To assess the usefulness of locally used template for cases of sexual assault

**Methods** Case notes of 36 patients treated for sexual assault who attended the clinic from January 2013 to March 2014 were reviewed. A questionnaire was designed to collect data and the data was analysed using Microsoft excel.

**Results** 44 case notes were identified but 36 cases fulfilled the inclusion criteria. Of the 14 auditable outcomes, only documentation of essential criteria (standard 1) reached the 100% standard and six achieved above 75% of the expected standard of 100%. These include documentation of physical injuries, self-harm risk assessment, offer of emergency contraception, offer of active vaccination against Hepatitis B and assessment of child protection need. Offer of baseline STI screening was documented in 72%. Poor documentation of BASHH criteria on further referral for physical injuries (33%) and repeat testing for STIs (36%) were identified.

**Discussion/conclusion** Importance of complete documentation on sexual assault cases should be emphasised. Reviewing the sexual assault template to capture all necessary information was identified as a result of this audit.