training could be improved with requests for a formalised attachment, formal qualification and greater training in practical procedures.

The BASHH GD SIG, in liaison with BASHH, aims to optimise GD training for registrars. Plans for improved resources are in progress, including a practical skills course and e-learning.

P192 SUDDENLY YOU'RE ON YOUR OWN, AND YOU'RE OUT THERE IN THE BIG WORLD: MIDDLE-AGED ADULTS' SEXUAL RISK-TAKING BEHAVIOURS WITHIN THE CONTEXT OF LIFE-COURSE TRANSITIONS

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Background/introduction While sexual activity, including partner change, is known to continue throughout the life course, there is a paucity of qualitative evidence on how adults over 45 years engage with risk for sexually transmitted infections (STIs), limiting the scope for effective health promotion among this age group.

Aims/objectives The research aimed to explore older adults' sexual risk-taking behaviour within the context of sexuality in later life.

Methods A qualitative in-depth study involving 31 interviews with middle aged heterosexual men and women aged 45 to 65, recruited from sexual health clinic and community settings.

Results Vulnerability to STI risk emerged around key life course transitions, including following divorce, separation and bereavement. Some spoke enthusiastically of embracing sexual freedom and pleasure within a perceived changed culture, resulting in frequent partner change; however, many found themselves 're-engaging' with their sexual careers within an unfamiliar gendered landscape. Lacking an (ageing) body confidence led to the prioritisation of intimacy over STI risk; condoms were viewed as being for birth control and therefore mostly unnecessary, or linked with casual sex and lack of trust. STIs were commonly considered to be a young person's concern.

Discussion/conclusions Information provision alone will not be enough to counter the complexities of navigating the dramatically different sexual landscape these older adults find themselves within compared to their youth, particularly those who have emerged from long-term relationships. A separately focussed approach to STI prevention taking account of life course experience, ageing and cultural change is advocated.

P193 DEVELOPMENT OF A HANDHELD POINT OF CARE MOLECULAR DIAGNOSTIC DEVICE FOR SEXUALLY TRANSMITTED INFECTIONS

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Background/introduction Brunel DoCLab is part of the *e*STI2 Consortium which is developing electronic self-testing and portable instruments for sexually transmitted infections using nucleic acid amplification test technologies. We have designed a point of care test platform that integrates a proprietary sample collection device directly with a microfluidic cartridge. A low cost benchtop real-time isothermal amplification platform has been developed capable of running six amplifications simultaneously.

Aim(s)/objectives To evaluate the sample preparation and isothermal amplification within the low cost diagnostic platform.

Methods The microfluidic device incorporates passive mixing of the lysis-binding buffers and sample. Cell lysis, within the cartridge, is conducted using a chemical method and nucleic acid purification is done on an activated cellulose membrane. Isothermal amplification was conducted using recombinase polymerase amplification (RPA).

Results Preliminary results have shown extraction efficiencies for this new membrane of 69% and 57% compared to the commercial Qiagen extraction method of 85% and 59.4% for 0.1 ng/μL and 100 ng/μL salmon sperm DNA respectively spiked in phosphate buffered solution. Extraction experiments in the passive mixer cartridges with lysis and nucleic acid purification showed extraction efficiency around 80% of the commercial Qiagen kit. The platform is capable of detecting *Chlamydia trachomatis* genomic DNA within 10 min using RPA for 100,000 copies/μL.

Discussion/conclusion The work presented here shows a low cost, rapid nucleic acid extraction, isothermal amplification and detection platform for diagnosing C. trachomatis. Work is ongoing to fully integrate the sample-in to result platform for rapid diagnosis of STIs using genital samples.

P194 COST-EFFECTIVENESS OF CHLAMYDIA TESTING IN SCOTLAND

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Background/introduction Scottish chlamydia testing guidelines target symptomatic and high-risk asymptomatic individuals. Recent publications, indicating a low risk of progression to serious chlamydia-related outcomes, particularly tubal factor infertility (TFI), question the validity of high levels of opportunistic testing especially among asymptomatic individuals.

Aim(s)/objectives To examine cost-effectiveness of current chlamydia testing to prevent TFI among those aged 15–24 in Scotland using cost per Quality-Adjusted Life Years (QALYs) gained and to consider alternative testing strategies.

Methods A compartmental deterministic model of chlamydia infection in those aged 15–24 in Scotland was developed to examine the impact of testing coverage and partner notification (PN) on number and cost of TFI cases prevented. Cost-effectiveness calculations were informed by best estimates of the QALYs lost due to TFI.

Results At 16.8% baseline testing coverage (laboratory data), 4.4% prevalence (NATSAL-3) and assumed PN rate of 0.4, the total testing cost is £5.4 million. This is estimated to prevent 258 TFI cases each year in young women. The cost per QALY gained is £40,034 compared with no testing, using a mid-range health state utility value (HSUV) for TFI (0.76 (±0.24)) and PID (0.9 (±0.22)). A 50% reduction in current testing would result in higher chlamydia prevalence and 84 more TFI cases.

Discussion/conclusion Current chlamydia testing activities in Scotland do not appear cost-effective. However, the model is sensitive to several parameters, particularly the HSUV and there are uncertainties in the current testing costs and progression to

serious sequelae. There appears potential to improve chlamydia testing cost-effectiveness by increasing PN.

P195 SHOULD MALE CIRCUMCISION BE CONSIDERED CURATIVE TREATMENT FOR LICHEN SCLEROSUS?

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Lichen Sclerosus is a chronic inflammatory skin disorder. In men it presents mainly on the prepuce, coronal sulcus and glans penis. The cause of lichen sclerosus is not fully understood, but genetic and autoimmune factors are thought to be important. Infections have been investigated as a cause, but with no clear evidence of a potential causative agent. In men the association with autoimmune diseases is weaker; however studies have shown a family history of diabetes mellitus, and thyroid disease are possible risk factors. Other suggested potential causes are chronic intermittent damage by urine, as early circumcision seems to be preventative in those who do not have congenital anomalies such as hypospadias.

Recommended treatments include circumcision and potent topical steroid ointments. Taking this into consideration we reviewed notes of patients that presented to the monthly Joint Dermatology clinic with a diagnosis of lichen sclerosus to ascertain the number of recurrences post circumcision.

We found four cases of recurrence of lichen sclerosus in patients attending the clinic over a four month period. Ages varied between 39–81 years old. One patient had diabetes mellitus, and another had been circumcised twice. All patients needed treatment with potent topical steroid ointment. Lipscombe *et al*. stated that 50% of patients who had a circumcision had a recurrence. It is important when discussing management with patients to remember that lichen sclerosus can recur after circumcision. From our observations, the presence of folds of skin still covering the glans penis best predicts recurrence.

P196 VULNERABILITY FACTORS IN VICTIMS OF SEXUAL ASSAULT PRESENTING TO A RURAL SEXUAL HEALTH CLINIC

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Background/introduction The Office for National Statistics show that 1/5 of women and 1/40 men over 16 years report having been a victim of sexual assault (SA).

Aim(s)/objectives To identify vulnerability factors (VFs) including alcohol/substance misuse and mental health conditions, in patients presenting as a direct result of a SA or who disclose a previous SA during a routine consultation.

Methods Retrospective notes review of 2 patient groups to identify VF disclosure;

1. All new presentations during a 2 week period disclosing previous SA during their consultation.
2. All presentations to sexual health over a 3 month period directly related to a SA.

Results Group 1: 291 attendances. 19 (6.5%) (16 female, 3 male) disclosed previous a SA, 3 were <18 yrs.

Group 2: 34 attendances (32 females, 2 males) aged 13–61 years (8 were <18 years). Those with VFs are shown in the table below.

Abstract P196 Table 1 Vulnerability factors for sexual assault

	Number of Patients (%)	
Vulnerability Factors (VF)	**Group 1**	**Group 2**
High Alcohol Intake	5 (26)	10 (29)
Recreational Drug Use	5 (26)	5 (15)
Previous Sexual Assault	n/a	11 (32)
Previous Domestic Violence	Not Available	5 (15)
Known to Social Services	3 (16)	12 (35)
Looked after Child	2 (11)	2 (6)
Vulnerable Adult	3 (16)	6 (18)
Mental Health Condition	7 (37)	20 (59)
Patients with 2 or more VFs	10 (53)	18 (53)

Discussion/conclusion Over 50% of patients had 2 or more identifiable VFs. Increasing staff awareness of VFs and improving links with support services may help to reduce the risk of sexual assault in vulnerable groups by allowing earlier identification of those at risk.

P197 DOWN WITH THE KIDS – ARE WE DOING ENOUGH TO PROVIDE A HOLISTIC SEXUAL HEALTH SERVICE TO VULNERABLE YOUNG PEOPLE?

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Background/introduction The sexual health of young people in the UK is amongst the worst in Europe, with high prevalence of sexually transmitted infections (STIs) and unwanted pregnancies. Although most are involved in consensual sexual activity, they may also be victims of sexual abuse or exploitation, usually unrecognised by themselves or health care professionals.

We have developed a proforma based on the BASHH young persons' proforma for patients under 18 attending the service which includes safe guarding issues.

Aim(s)/objectives To review the management of young persons' sexual health in an inner city sexual health clinic.

Methods Retrospective case note review of all patients <18 years attending clinic in 2012 and 2013.

Results 93 patients were identified; 34 (36.6%) were <16 years (7 M; 27F); median age 15 years (range 11–15). 32 (94.1%) were sexually active; all (100%) of which accepted STI screening. 14 (45.2%) tested positive for at least one STI. The proforma was completed for 33 (97.1%) patients.

14 (41.2%) of the patients had contact with social services; 10 (29.4%) had non-consensual sexual activity; 15 (44.1%) had mental health issues and 4 (11.8%) used recreational drugs. All of them have been followed up according to local guidelines.

Conclusion The proforma enables us to identify those with safeguarding issues and STIs. An appropriate safeguarding referral pathway and local multi-agency arrangements are in place to help and protect these young people. Further education and communication are needed to raise the awareness and improve the sexual health and wellbeing of the young people.