Results In 2011, 98 case notes were reviewed. The rate of infection was 28.2%.

In 2013, 89 case notes were reviewed. The overall rate of infection fell to 14.6%. However, 46% had never attended our GUM clinic and among these the infection rate was 22%. The comparative rate in MSM attending clinic was 8.7%. Of those new to our services 19% had never attended any GU service and of these 82% had never tested for HIV.

Conclusion Our outreach team tested a significant number of patients with a high burden of infection who had never accessed services. However, the team is taken from conventional clinics; due to staff shortages in the clinic, patients are turned away. A balance needs to be found between financial constraints and reducing infection in hard-to-reach populations. Collaboration with voluntary organisations and saunas will be the key to our success. We are currently setting up a Chem-Sex clinic to target evolving at risk populations.

Background/introduction This sauna clinic was set up as recent HIV infection amongst MSM in our city is higher than the national average. Following a successful 6 month pilot, the clinic was commissioned for another year.

Aim(s)/objectives
- Provide accessible, convenient sexual healthcare/promotion for ‘hard-to-reach’ individuals.
- Promote regular STI testing amongst this high-risk group.
- Assess measurable outcomes to determine the service’s success.

Methods A weekly nurse-led clinic was set up at the sauna. Rectal, pharyngeal and urine testing for chlamydia and gonorrhoea were offered, with HIV, hepatitis B/C and syphilis testing and Hepatitis B vaccination. Identified infections were treated at the sauna clinic or our GUM clinic.

Results 231 new/rebook episodes over 57 clinics. 80% had previously accessed sexual health services but only 63% had previously undergone extra-genital sampling. HIV testing uptake was 96%, 16% had never tested for HIV; 22% last tested over a year ago. 20% reported sex with men and women. 18% had at least one of chlamydia, gonorrhoea, HIV or syphilis identified, compared with 14% amongst asymptomatic MSM attending our GUM clinic. 80% of chlamydia and gonorrhea infections identified were purely extra-genital. 6 new HIV diagnoses were made, 4 of which were recently acquired HIV. HIV prevalence was 3%.

Discussion/conclusion The service has been continually modified to optimise attendance. A new initiative introduced by the sauna management team includes discounted sauna entry for clients attending the sauna clinic. This clinic’s success has been due to close partnership and collaboration between NHS, third sector, private sector and local commissioners.

Sexually active young people can be at risk of child sexual exploitation (CSE). It has been assumed that the presence of a sexually transmitted infection (STI) should be used as a marker of increased risk, however no clear evidence exists to support this.

Aim(s)/objectives We aimed to identify if a relationship exists between the detection of STI and other indicators for CSE, by comparing to a matched control group who tested negative for STI.

Methods Utilising our service’s electronic patient record, which automatically prompts staff to risk assess, we identified that 1228 patients aged 15 yo were seen between 01/04/2013 and 31/03/2014, 52 of whom tested positive for STI. Their notes, plus a control group of 105 patients were reviewed for potential identifiers of CSE.

Results We identified no statistically significant association between testing positive for STI and other predictive factors for CSE.

Discussion/conclusion In this small study we found no significant increase in commonly used indicators for CSE in those who tested positive for STI. This highlights the importance of using several identifiers when assessing for CSE and the need for incorporating alternative screening tools such as Spotting The Signs.
### Abstracts

#### Abstract P228 Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of Gonorrhoea diagnoses</th>
<th>Number of Gonorrhoea diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (total)</td>
<td>Female (gender and total)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Number of GUM attendances (%)</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>总人数</td>
<td>性别总计</td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>211 (22.0%)</td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>135 (21.0%)</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>482 (21.5%)</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>237 (21.5%)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>965 (20.9%)</td>
</tr>
</tbody>
</table>

There were 99 Gonorrhoea diagnoses in patients, 94/99 (84.4%) in females and 15/99 (15.2%) in males (5/13 (33.3%) MSM). 1/84 (1.2%) was HIV+ (MSM). 26/99 (26.2%) infections were in White, 19/99 (19.2%) in Caribbean/Mixed-Caribbean, 11/99 (11.1%) in African/Mixed-African and 7/99 (7.1%) in Other-Mixed ethnicities. 80/84 (95.2%) were UK born. Age range was 15–18.

83/99 (83.8%) were genital and 12/99 (12.1%) were multiple site infections. We found concurrent Chlamydia in 53/99 (53.3%). Antimicrobial resistance was detected in 15/68 (22%) culture+ cases, 13/15 (86.7%) in females and 2/15 (13.3%) in MSM. 11/84 (13.1%) patients had ≥1 re-infection (positive test at ≥3 months), 10/11 (90.9%) females and 1/11 (9.1%) MSM. Mean time to re-infection was 5.1 months.

**Discussion**

NAAT testing was introduced into our service preceding the study period. We found Gonorrhoea diagnoses in patients ≤18 have increased three-fold in 4 years in our clinic with high rates of Chlamydia co-infection, antimicrobial resistance and re-infection. MSM, females and patients of Black/Mixed ethnicity are disproportionally affected. Further work is required to investigate factors contributing to the observed rise in Gonorrhoea in YP, and strategies to reduce infection rates.

### Category: Viral sexually transmitted infections

#### P230 WITHDRAWN

#### P231 WITHDRAWN

#### P232 CASE REPORT: AN HIV POSITIVE PATIENT WHO HAS TWICE SPONTANEOUSLY CLEARED HEPATITIS C INFECTION

Pippa Green*, S Ahmad. University Hospital of South Manchester, Manchester, UK

10.1136/sti-2015-052126.274

**Introduction**

A 26% spontaneous clearance rate of Hepatitis C (HCV) in HIV negative populations is estimated, although the extent may be higher. Spontaneous clearance rates in HIV/HCV co-infected populations are lower. We report an HIV positive patient who has twice spontaneously cleared acute HCV infection.

**Case report**

A 43 year old MSM diagnosed HIV positive in 1999 (WT virus, Nadir CD4 300) had evidence of past resolved Hepatitis A and B at time of HIV diagnosis. He commenced antiretroviral therapy (ARVs) in 2001 achieving virological suppression (VL ≤40). Hepatitis C was diagnosed in 2008 on tests prompted by raised LFTs: HCV antibody positive, HCV RNA 55 iu/ml, genotype not available. HCV antibody was negative 12 weeks earlier. Seroconversion was asymptomatic and associated with a transient rise in serum alanine transaminase (peak 189). HCV RNA was undetectable 2 weeks later and remained so for 5 years. He re-presented with symptomatic acute Hepatitis C in 2013: HCV RNA 59258 iu/ml, genotype 1, ALT 519. ALT normalised and HCV RNA fell to the limit of sensitivity of the assay (12 iu/ml) within 2 weeks. HCV RNA remained negative 1 year later. Re-infection occurred during a self imposed ARV treatment interruption and was associated with injecting drug use, high sexual risk taking behaviour and co-infection with bacterial STIs. Acute HCV was diagnosed within 4 weeks of restarting ARVs.

**Discussion**

As spontaneous clearance of HCV in HIV/HCV co-infected individuals is less common than those mono-infected, it is of interest that this patient has twice spontaneously cleared HCV.

#### P233 IS ROUTINE BLOOD MONITORING FOR SUPPRESSIVE HERPES TREATMENT NECESSARY?

Bridie Howe, Mei Liew, Stephen Bubury*, Robert Lapham, Jane Hussey. Department of Genito-Urinary Medicine, City Hospitals Sunderland, Sunderland, Tyne and Wear, UK

10.1136/sti-2015-052126.275

**Background**

There is no published evidence on the need for routine blood monitoring for people requiring daily oral acyclovir. Locally clinical practice differed between services. Dose reduction in moderate to severe renal impairment is recommended. Guidance for intravenous administration recommends measuring full blood count (FBC), renal (U&E) and liver function (LFTs) periodically.