Background/introduction Centralised management of positive results by a 'Partner Notification Bureau' has been suggested by the National Chlamydia Screening Programme. From September 2014 positive results for chlamydia and gonorrhoea from primary care were reported directly to the sexual health service in a UK city for management.
Aim(s)/objectives To evaluate the effectiveness of centralised management of treatment and partner notification (PN) by assessing outcomes for the first year and to estimate impact on health adviser workload.
Methods Health adviser records were reviewed retrospectively to assess outcomes in terms of : patients informed of their result, confirmed treated at any service, and offered PN discussion; partners attended.
Results Gonorrhoea: between September 2014 and August 2015 there were 46 positives reported (31 female). Forty five were informed, confirmed treated, and had a PN discussion by phone. The number of partners reported or verified attended per case was 0.8 (37/46). Chlamydia: Between September 2014–August 2015, 457 positives were reported (352 female). Of these, 440 (96%) were informed and had PN discussion, and 448 (98%) were confirmed treated. The number of partners reported or verified attended per case was 0.98 (450/457). Outcomes for both exceeded the national PN standard of 0.6 partners attending per case. Partner notification workload increased by approximately 10%.
Conclusion Centralised management of gonorrhoea and chlamydia positives from primary care resulted in excellent treatment rates and PN outcomes. However, additional health adviser resources are required to manage the extra workload.

Section 2 Oral Case Presentations

CC1 "PERSISTENT GENITAL AROUSAL DISORDER – THE EXPERIENCE OF A LONDON TEACHING HOSPITAL"

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10.1136/sextrans-2016-052718.40

Background Persistent genital arousal disorder (PGAD) is a condition seen mainly in women characterised by spontaneous and often unrelenting sensation of genital arousal in the absence of sexual desire or stimulation. These sensations typically do not fully remit with orgasm and are by definition intrusive and distressing. The condition overlaps in some cases with pudendal neuralgia but needs to be differentiated from hypersexuality. Patients may present preferentially to GUM clinics in the knowledge that sexual symptoms will not be trivialised. Different opinions exist as to triggers, causes and treatment. Taking this into consideration we analysed a cohort of patients with PGAD assessing whether they were any common themes in terms of precipitating and relieving factors.
Aim To describe our clinical experience and ascertain number of patients with diagnosis, common themes and treatment modalities.
Methods 57 patients were diagnosed with PGAD since departmental code was introduced in 2006 and 39 patients notes were located and reviewed.
Results Of these 69% were in a relationship and 64% had no history of past sexual abuse. Relieving factors were also varied among the cohort including masturbation and distraction. 95% were referred for mindfulness cognitive behavioural therapy and 51% were on medication such as amitriptyline, gabapentin, venlafaxine and nortriptyline. 72% were referred for pelvic floor physiotherapy.
Discussion PGAD is rarely seen estimates say 1–6% are affected by this hence it is important as sexual health clinicians to be aware of it to reduce delays in diagnosis. Overall management of PGAD requires a holistic approach with multidisciplinary team involvement.

CC2 DOES MYCOPLASMA GENITALIUM CAUSE PROCTITIS? A CASE REPORT

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10.1136/sextrans-2016-052718.41

Background/introduction Mycoplasma genitalium is an emerging sexually transmitted pathogen implicated in urethritis in men and cervicitis and pelvic inflammatory disease in women. The overall prevalence of rectal mycoplasma genitalium was 4.4% in one study of MSM. However, symptomatic disease is not well reported.
Aims/objectives We describe a case of symptomatic rectal mycoplasma genitalium
Methods Retrospective case not review
Results A 19 year old MSM attended with a 2 week history of rectal bleeding, discharge and tenesmus. His last sexual contact was 6 weeks previously: condom-less receptive anal intercourse. On examination, he had no lymphadenopathy, no rash and no evidence of oral ulceration. On proctoscopy, he had erythematous mucosa and multiple small discrete rectal ulcers. Triple site swabs were taken including gonorrhoea culture, rectal swab for LGV and multiplex PCR (syphilis, HSV and mycoplasma genitalium). A full blood borne virus screen was performed. He was treated with ceftriaxone (500 g IM), azithromycin (1 g PO), doxycycline (100 mg PO BD for 7 days) and acyclovir (400 mg PO TDS for 5 days) but his symptoms did not resolve. All tests were negative except rectal multiplex PCR was positive for mycoplasma genitalium. He was diagnosed as having symptomatic mycoplasma genitalium infection and was treated with a prolonged course of azithromycin. His symptoms subsided.
Discussion/conclusion Mycoplasma genitalium has been found in the rectum of MSM and is usually asymptomatic. We describe a case of proctitis which seems to be related to Mycoplasma genitalium. MSM with unresolved proctitis should be tested for Mycoplasma genitalium.

CC3 LYMPHOGRANULOMA VENEREUM PRESENTING AS A RECTAL TUMOUR

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Background/introduction Lymphogranuloma Venereum (LGV), due to an invasive serovar of Chlamydia Trachomatis, is endemic in the United Kingdom in men who have sex with men (MSM). It is associated with the human immunodeficiency virus (HIV) and other sexually transmitted infections including hepatitis C.
Aim(s)/objectives We present a case of LGV mimicking a rectal tumour in a heterosexual male.

Methods The diagnosis of LGV was made following molecular diagnostic testing of an anal swab.
Results The patient presented as an emergency with a history of change in bowel habit, tenesmus and rectal bleeding. He had a past medical history of duodenitis and a family history of Crohn's disease. Digital rectal exam revealed a circumferential rectal tumour, 2 cm from the anal verge. Features suggested a diagnosis of rectal cancer and radiological staging demonstrated extensive local infiltration and nodal involvement, supporting this diagnosis. Biopsies from colonoscopy however revealed severe proctitis with no evidence of malignancy. The local colorectal MDT meeting decided the patient would have neoadjuvant chemoradiotherapy and subsequent surgery based on response, after more biopsies. In the interim he presented with pending bowel obstruction resulting in a de-functioning colostomy and the patient tested positive for HIV prompting a referral to GUM physicians. Repeat MRIs captured the subsequent remarkable response to LGV treatment with Doxycycline.
Discussion/conclusion It is important for HIV testing to be incorporated as part of the management plan for colorectal malignancies.

CC4 OCULAR SYPHILIS ON THE RISE: A CASE SERIES

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Background Ocular involvement of syphilis remains relatively rare, however our clinic has seen a recent flurry of cases with 13 new diagnoses in the last 2 years, compared with 11 seen in the proceeding 10 years. It can be difficult to diagnose with no pathognomonic signs and can affect any structure of the eye.
Aim To present a cluster of 13 new cases ocular syphilis diagnosed from 2013 until January 2016.
Methods A retrospective case review.
Results In conjunction with our tertiary eye hospital, our clinic saw 13 patients diagnosed with ocular syphilis between July 2013 and January 2016. All 13 patients were male: 6 heterosexual; 5 men who have sex with men (MSM) and 2 bisexual. 3 patients were HIV positive. Mean age 42 (range 22–75). Ocular involvement included uveitis (anterior, posterior and pan-), optic neuritis, papillitis and retinitis. Cases include both unilateral and bilateral symptoms. All were treated as per national guidelines for neurosyphilis with procaine penicillin plus probenecid, proceeded by oral steroids. The majority of these patients' symptoms resolved following treatment, however a few continue to have ongoing visual disturbances.
Discussion We present our 13 cases of ocular syphilis. They illustrate the diverse range of presentations of ocular syphilis and the importance of partnership between the GU clinic and specialist ophthalmology services.

CC5 A CASE OF URTICARIAL VASCULITIS LEADING TO HIV DIAGNOSIS

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This abstract has been temporarily removed while important corrections are made.

CC6 WARNINGS ARE NOT ENOUGH – A CASE SERIES OF RITONAVIR INDUCED CUSHING'S SYNDROME AND ADRENO-CORTICAL FAILURE

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10.1136/sextrans-2016-052718.45

Background Ritonavir is a potent inhibitor of the cytochrome P450 3A4 enzyme used to boost other protease inhibitors in the management of HIV infection. The metabolism of fluorinated steroids (eg fluticasone, triamcinolone), used for asthma, hay fever and arthritis, is inhibited by ritonavir causing increased exposure to corticosteroid. Cases of ritonavir induced Cushing's syndrome and subsequent adrenocortical suppression were first reported in 1999. Despite awareness of this interaction new cases continue to occur.

Aim To identify and describe patients in our cohort with iatrogenic Cushing's ± adrenocortical suppression, and to investigate whether there were missed opportunities for prevention.
Methods Cases were identified from laboratory and pharmacy records between January 2010 and December 2015. Data was collected on demographics, steroid use, presentation and outcome. GP and referral letters were reviewed.
Results 25 cases were identified. The steroids were prescribed in many different specialties, most commonly primary care and rheumatology, as well as being obtained OTC. Duration of steroid use ranged from a single dose to 3 injections over one year. The most common presentation was weight gain, facial swelling, fatigue and postural dizziness. Long-term sequelae included diabetes, osteoporosis and avascular necrosis as well as creating