Aim(s)/objectives Our aim was to investigate the factors associated with recurrent bacterial STIs in MSM in Brighton, focusing specifically on drug and alcohol use.
Methods We reviewed MSM presenting to our service between September 2014-September 2015 who had had 3 or more repeat attendances with a bacterial STI. We included infectious Syphilis, pharyngeal, rectal and urethral Chlamydia and Gonorrhoea. We collected data on alcohol and recreational drug use.
Results An estimated 11,000 MSM attended during the study period. Of these, 46 MSM had 3 or more bacterial STIs. The median age was 34.5 years 21–57). 26/46 (57%) were HIV positive. 32/46 (70%) had 3 STIs; 10/46 (22%) had 4 STIs, 3/46 (7%) had 5 STIs and 1/46 (2%) had 6 STIs. 14/46 (30%) reported hazardous drinking, 31/46 (67%) reported use of party drugs (including Mephedrone, Crystal Meth, Ecstasy and GHB) and 7/46 (15%) reported 'slamming'.
Discussion/conclusion MSM attending multiple times with recurrent bacterial STIs also report high use of alcohol and recreational drug use including slamming. Public health interventions to reduce incidence of STIs should include focusing on drug and alcohol use in MSM.

P053 HIV SCREENING IN THE HIV NEGATIVE POPULATION – A REGIONAL HIV NETWORK AUDIT OF SCREENING OFFER, UPTAKE AND TURN-AROUND TIMES

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Background New BHIVA Standards of care for people living with HIV were published in 2013 for proportion of people newly attending sexual health services offered an HIV test in and time from HIV testing to lab reporting and sharing result with patient
Aims Baseline regional audit to assess HIV screening offer, uptake and turn-around times within sexual health services to feedback to commissioners.
Method Standards set from the 'Management of Sexually transmitted Infections' MEDFASH 2014. Retrospective audit of first 30 attendances between 01/09/14 and 30/11/14. Services reviewed notes coded as either HIV testing performed, inappropriate or declined. Information collected included documentation of offer, reason given for decline or deemed inappropriate. For those tested, times taken for lab reporting and sending patient result text was collected.
Results 8 services took part. 0.1% HIV positivity rate. 70% overall had documented reason for HIV test decline. 13% were coded as declined with no documented offer. Percentage of people with needs relating to STI's who had an HIV test at first attendance 97% offered (achieved in 84%, range 59 to 100%), 80% uptake (achieved in 70%, range 47 to 87%). 3/8 of services met both standards for turn-around times. Overall 92% of services received report from laboratory within 5 working days, range 1 to 20 days (standard 97%) and 90% of patients received their result within 10 working days, range 3 to 30 days (standard 95%).
Discussion Not all patients appropriate to be tested were offered HIV test, training as to when HIV testing is not appropriate in Sexual health was recommended. Patients in a long term relationship were most likely not to be offered screening, regardless of previous screening history. There was a large variation between processing times in both laboratories and sexual health services. Good practices for those meeting standards were shared with the network.

P054 PELVIC INFLAMMATORY DISEASE (PID) – IS TELEPHONE FOLLOW-UP FEASIBLE, SAFE AND EFFECTIVE?

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Background BASHH guidelines recommend follow up after PID treatment. A previous clinic audit highlighted high DNA rates for such appointments. In October 2013 we introduced a telephone follow-up protocol for PID to reduce unattended appointments without compromising patient safety and satisfaction. Patients diagnosed with PID were referred to the Health Advisor (HA) at the first consultation to commence the Partner Notification (PN) process. HA's then conducted a telephone follow-up appointment 2 weeks later to ensure treatment compliance and review symptoms.
Aim To audit the performance of the new PID telephone follow-up protocol and estimate number of appointments saved.
Method A 3 months retrospective electronic case note and PN record review of female patients diagnosed with C5A attending between 1/7/14 and 30/9/14.
Results 59 eligible case notes reviewed. Mean age = 25.8 years. 66% (39/59) patients received telephone follow-up. 71% (28/39) patients contacted on first attempt and all were happy to be telephoned. As per PID protocol 23% (14/59) patients with positive Chlamydia, gonorrhoea test or IUD in situ were advised to attend for doctor review. Of these 36% DNA'd their clinic follow up appointment. PN rates 0.8%.
Discussion PID follow up performed by HA telephone consultation is acceptable to patients and HCP's. We saved 39 doctors appointments over 3 months and there was no impact on PN rates or patient safety. Since this audit we now include patients with Chlamydia and IUD's in the telephone follow-up protocol, and men with Epididymo- orchitis. We estimate we could save 280 follow-up appointments a year.

P055 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEA 2007 - 2015

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Background/introduction This was a retrospective analysis of clinic performance in the management and treatment of *Neisseria gonorrhoeae* (GC) according to the current British Association of Sexual Health and HIV (BASHH) guidelines.
Methods All cases of GC diagnosed in our clinic between 1st January and 30th June 2015 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared to data collected at the same clinic for the

same six months in 2007 to 2014. The total number of cases identified in 2015 were 151.

Results

Abstract P055 Table 1

	2007	2008	2009	2011	2012	2013	2014	2015
TOC (%) (Had TOC%)				– (36)	91 (66)	84.6 (53)	91 (60)	91 (60)
C4 Treatment (%)	100	100	100	98.60	100	100	100	99.3
PN (%)	82	95	92	98.60	100	100	100	96.7
PIL (%)	32	64	81	61	50	66	27	74
1st line (%)	77	96	100	97	88	100	97	93.4

Discussion/conclusion To my knowledge, this is the longest continuous audit of the management of *N.gonorrhoea* in the UK. I have seen continuous improvements in the performance of all five domains. We introduced an electronic reminder to provide patients with an information leaflet at the end of 2014. This has shown a marked improved from 27% to 74%. We aim to achieve full BASHH compliance in 2016.

P056 INFLUENCE OF COUNTRY OF BIRTH ON RISK OF STI DIAGNOSIS AMONG BLACK CARIBBEANS IN ENGLAND IN 2014

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Background/introduction In England, people of Black Caribbean (BC) ethnicity are disproportionately affected by sexually transmitted infections (STIs), but it is unclear whether this is associated with their country of birth.

Aim(s)/objectives To examine differences in STI diagnoses among UK- and Caribbean-born BC people.

Methods Data on STI diagnoses in BC people attending genitourinary medicine (GUM) clinics and living in England were obtained from the GUM Clinic Activity Dataset (GUMCADv2). Associations between being UK- or Caribbean-born and diagnosis with an STI were derived using univariate and multivariable multilevel logistic regression models adjusted for age, gender/sexual-orientation, residence, and HIV status.

Results BC people made 231,719 attendances in 2014; 81.9% were UK-born. The median age (years) was 25 for UK-born and 34 for Caribbean-born people ($p \leq 0.001$). Chlamydia, non-specific genital infection and gonorrhoea were the most commonly diagnosed STIs among UK- (37.4%, 19.5% and 13.7%) and Caribbean-born attendees (32.1%, 25.2% and 13.1%). From the multilevel analysis, UK-born attendees were less likely to be diagnosed with chlamydia (aOR 0.87 [95%C.I. 0.81–0.94]) and trichomoniasis (0.83 [0.71–0.97]), and more likely to be diagnosed with genital warts (1.24 [1.07–1.45]) than Caribbean-born attendees. The adjusted odds of a gonorrhoea diagnosis did not vary by country of birth.

Discussion/conclusion STI rates among black Caribbeans attending GUM clinics in England are high and might be influenced by STI epidemiology in their country of birth. Studies on the effectiveness of interventions aimed at reducing the burden of STIs in all black Caribbeans are urgently needed.

P057 NEISSERIA GONORRHOEA (GC): PERSISTENCE OF DNA DETECTION AFTER SUCCESSFUL THERAPY AND CHANGING PATTERN OF ANTIBIOTIC SENSITIVITY, 2007–2015

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Background/introduction Nucleic acid amplification testing (NAAT) is widely used in GUM clinics to diagnose GC infection; its in-built high sensitivity may potentially detect DNA from non-viable organisms following successful treatment. The BASHH national guidelines stipulate that test-of-cure (TOC) with NAAT should take place 2 weeks post-treatment. The purpose of this study was to determine whether this is an adequate time interval to perform TOC. We also analysed the changing pattern of antibiotic sensitivity between 2007–2015.

Aim(s)/objectives All GC cases at our clinic between 1st January and 30th June in 2007–2015 were identified and assessed for antibiotic sensitivity and TOC.

Methods In 2015 there were 151 cases; culture and sensitivity results were available for 99 cases. TOC with NAAT was done in 81 cases. There were 10 cases where the NAAT was SDA positive but PCR negative. Overall a TOC with NAAT was performed between 7 and 50 days post-treatment with a mean, median and mode of 17, 14 and 14 days respectively.

Abstract P057 Table 1 Gonorrhoea 2007–2015

	2007	2009	2011	2012	2013	2014	2015
% fully sensitive	46	67	59	49	79	59	43
Resistance to 1 antibiotic group	27	15	20	38	10	20	23
Resistance to 2 antibiotic groups	15	10	16	8	6	13	21
Resistance to 3 antibiotic groups	12	2	5	3	2	8	5

Conclusion None of the cultures were resistant to ceftriaxone. However prevalence of multi-drug resistance in N.gonorrhoea has shown gradual decline from 27% in 2007 to 8% in 2013. The trend has reversed in 2014 with increasing multi-drug resistance to 26% in 2015. Since 2013 I have also looked at the persistence of DNA detection following successful therapy and this supports the BASHH Guidelines of TOC 2 weeks post treatment.

P058 TWO CASES OF DELIBERATE ANTIRETROVIRAL OVERDOSE: RALTEGRAVIR AND TENOFOVIR DISAPROXIL FUMARATE/EMTRICITABINE

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Background/introduction There is a high incidence of psychiatric illness amongst those living with HIV. This is associated with a risk of deliberate self harm including overdose with antiretrovirals. There are a small number of publications describing overdose with antiretrovirals but none describing overdose with raltegravir.

Aim(s)/objectives In this report we aim to describe two cases of overdose with antiretrovirals: the management, investigations and resultant complications.

Methods The patient case notes and laboratory test results were reviewed.