multiple partners). 194 (50%) had recently used recreational drugs (within 3 months; 34% "Chemsex" substances). 157 (41%) reported a recent STI (6 months). 223 (58%) reported that they strongly believed they would benefit from PrEP. However, 42/223 (19%) reported no condomless sex. Concerns around taking PrEP were cited by 76 (20%). 167 (43%) expressed a preference for daily PrEP; 139 (38%) for coitally-driven. 311 (80%) supported PrEP delivery by sexual health clinics to MSM, and 233 (60%) to any-one who requests it. 112 (29%) agreed a prescription charge was appropriate. 17 respondents (4%) reported having already taken PrEP: 35% using medication acquired as PEP, and 30% acquiring PrEP privately. 7/17 (41%) reported decreased condom since commencing PrEP.

Discussion/conclusion This comprehensive questionnaire study demonstrates a high willingness to use PrEP in a cohort of at-risk MSM. These data should inform the commissioning process of this efficacious biological intervention.

O015 ESTABLISHMENT OF A MONITORING SERVICE FOR MEN WHO HAVE SEX WITH MEN (MSM) TAKING GENERIC CO-FORMULATED TENOFOVIR DISOPROXIL FUMARATE (TDF)/EMTRICITABINE (FTC) AS PRE-EXPOSURE PROPHYLAXIS (PREP) AGAINST HIV INFECTION

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Background/introduction Truvada® (TDF/FTC) PrEP taken daily or intermittently reduces HIV acquisition by over 86%. However, PrEP is only available privately in the UK, costing upwards of £400 for 30 tablets. Online generic TDF/FTC is significantly cheaper at £35-£50 for 30 tablets. There are, however, authenticity concerns about online medicines. Additionally, HIV infection should be excluded in individuals taking PrEP and baseline assessments of hepatitis B and renal function performed which may not occur with online PrEP.

Since February 2016, we have provided assessment and therapeutic drug monitoring to individuals on generic TDF/FTC to ensure safety and medication integrity.

Aim(s)/objectives To review characteristics of individuals taking generic TDF/FTC.

Methods Service evaluation of individuals taking generic TDF/FTC attending a London sexual health service. Data on the first 44 patients were collected: demographics, HIV and renal function testing, hepatitis B status, baseline STIs, regimen, source of PrEP.

Results All MSM; mean age 41 years (28–73); 77% White; 33/44 (75%) on PrEP at time of attendance; all HIV antibody negative prior to commencement. Mean eGFR 81.5 ml/min, 65% had documented hepatitis B immunity. One STI (syphilis) was identified at baseline. 93% were taking daily PrEP and 86% obtained Cipla manufactured Tenvir-EM® from United Pharmacies. Tenofovir and FTC levels were measured in 18/44 (41%), all results demonstrating presence of adequate active compound.

Discussion/conclusion Numbers of individuals requiring monitoring on generic TDF/FTC are increasing. It is reassuring that so far, drug levels suggest appropriate quantities of tenofovir and FTC in Tenvir-EM®; however, more data are needed.

O016 RENAL FUNCTION AT BASELINE AND MONTH 1 IN THE PROUD STUDY, A PRAGMATIC OPEN LABEL RANDOMISED TRIAL OF TRUVADA AS PRE-EXPOSURE PROPHYLAXIS

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10.1136/sextrans-2016-052718.15

Background/introduction Quarterly monitoring of creatinine is likely to be recommended by WHO for those on PrEP, even though there were no significant differences in creatinine in placebo-controlled trials. Establishing the appropriate level of monitoring of PrEP is important.

Methods PROUD is an open-label, randomised trial of Truvada as PrEP in MSM. HIV serology and serum creatinine was done at PrEP baseline ('start'). Clinics were advised to collect creatinine or urinary protein-creatinine ratio (UPCR) if there was $\geq$1+ protein on urinalysis at the month 1 visit (m1). Here we present the renal monitoring results at "start" and m1 with eGFR (ml/min/1.73m^2) calculated by the CKD-EPI equation.

Results 445 (93%) of 481 had baseline creatinine, 13 (3%) had UPCR, and 23 (5%) neither. The median eGFR was 106. Only one was <60 (eGFR = 49), probably due to dietary creatinine supplementation. 260 (59%) of 443 had a m1 creatinine, creating 246 paired results. On average, eGFR was 1.50 lower at m1. Seven (4%) of 194 with eGFR >90 dropped 20%, one to 59. He stopped PrEP and did not attend thereafter. Of the 7, none had abnormal urinalysis; 4 had UPCR – all normal. 41 (79%) of 52 with eGFR 60–90 at baseline remained at this level, the remainder increased to >90.

Discussion/conclusion The mean change in eGFR at month 1 is not clinically significant. Excepting one individual who could not be further evaluated, there were no clinically meaningful changes at m1. Further work will explore the relationships between eGFR and proteinuria.

O017 CHEMSEX RELATED ADMISSIONS TO A CITY CENTRE HOSPITAL

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Background/introduction Recreational drug use (RDU), particularly the chemsex drugs mephedrone, crystal methamphetamine and gamma-hydroxybutyric acid (GHB) are associated with significant harms. Occasionally this has led to hospital admission with significant morbidity and mortality.

Aim(s)/objectives To review inpatient admissions from a large HIV service and look at RDU associations.

Methods A prospective analysis of admissions to an HIV inpatient service between April 2015 and March 2016 was conducted. Information was collected on demographics, admission details, complications and drug use.

Results From 194 admissions there were 19 (9.8%) related to RDU. Median age was 33.5 (range 23–65). All were male and 18 (94.7%) were men who have sex with men (MSM). 4 (21.1%) were Hepatitis C co-infected. 5 (26.3%) patients took

Abstract O017 Table 1 Chemsex-related admissions

Diagnosis	N (%)
Overdose	9 (47.4%), 4 ITU admissions
Psychosis	3 (15.8%)
Abscess	2 (10.5%)
Arrhythmias	2 (10.5%)
DVTs	1 (5.3%)
Withdrawal	1 (5.3%)
Rhabdomyalysis	1 (5.3%)

GHB, 5 (26.3%) mephedrone and 4 (21.1%) crystal meth. Cause of admission can be seen in Table 1. There were 3 deaths due to drug overdoses during the study period.

Discussion/conclusion RDU was responsible for 9.8% of admissions, with GHB, mephedrone and crystal meth responsible for 21–26%. This may underestimate the true effect of drug admissions as it only involves HIV positive MSM. We've developed a chemsex clinic and city-wide task and finish group, in liaison with Public Health to address the growing effect of chemsex. Clinicians need to ensure RDU is regularly reviewed and timely interventions are offered to limit harms.

O018 COMMUNITY VIRAL LOAD: A NEW POPULATION-BASED BIOMARKER OF HIV DISEASE BURDEN IN SCOTLAND

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10.1136/sextrans-2016-052718.17

Background/introduction "Community viral load" (CVL) refers to an aggregate biological measure of viral load (VL) for a particular geographic location. Studies have suggested that CVL may be used as a population-based biomarker for HIV transmission, and that its reduction is associated with a decrease in HIV incidence. Currently, there is no published data on CVL in Scotland.

Aim(s)/objectives This study aims to measure CVL and to estimate the HIV transmission potential of communities in Scotland.

Methods HIV/AIDS surveillance data on patient demographics, first VL in 2014, and region of residence were analysed. Mean CVL was measured as the arithmetic average and total CVL the arithmetic sum of all VL in our data set respectively. Statistical analyses were performed using SPSS 23 at 95% significance level. Shapiro-Wilk test was performed for normality. Chi-square analysis and Kruskal-Wallis test were performed for differences in variables. Spearman's correlation was performed for correlations between CVL and HIV incidence.

Results 4126 non-duplicate cases were analysed. Mean CVL was highest in Central South-West (CSW) (μ = 20,469, 95% CI = 8146–32,933), followed by Central South-East (CSE) and North respectively. There was a significant difference in mean rank CVL between North-CSW and North-CSE. There was a positive correlation between mean CVL and HIV quarterly incidence for CSW (Spearman's rho = 0.062, p = 0.01) and CSE (Spearman's rho = 0.032, p = 0.196), whereas a negative correlation was seen in North (Spearman's rho = −0.047, p = 0.202).

Discussion/conclusion This study highlights the relationship between CVL and HIV quarterly incidence in Scotland in 2014. Further work using annual incidence data is needed to verify these conclusions and to determine factors influencing these results.

O019 EXTRA-GENITAL SAMPLES FOR GONORRHOEA AND CHLAMYDIA IN WOMEN AND MSM: SELF-TAKEN SAMPLES ANALYSED SEPARATELY COMPARED WITH SELF-TAKEN POOLED SAMPLES

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10.1136/sextrans-2016-052718.18

Background Extra-genital infections are common in MSM and women and are frequently the sole sites of infection. However, analysing samples from the rectum and pharynx, in addition to the urogenital tract, trebles the diagnostic cost.

Aim Can samples from three sites be pooled into one NAAT container and still achieve the same sensitivity and specificity as the samples analysed separately?

Methods Women and MSM attending a sexual health clinic were invited into a 'swab yourself' trial. Two self-taken samples (one for separate analysis and one for pooling) were taken from the pharynx and rectum with VVS in women and FCU in MSM. The sampling order of the pooled or analysed separately swabs was randomised. Gonorrhoea (NG) and chlamydia (CT) were diagnosed using NAATs. Patient infected status was defined as at least two positive confirmed samples.

Results 1251 women and MSM were recruited to January 2016. Overall prevalence of infections was NG 5.7% and CT 17.8%. Sensitivity, specificity, PPV and NPV are shown in the table:

Conclusion This on-going study demonstrates that self-taken samples from the rectum, pharynx and urogenital tract are comparable in sensitivity and specificity if analysed separately or as a pooled sample. In MSM the diagnostic costs of three separate analyses are unaffordable for many health systems but a pooled sample has the same laboratory cost as a urogenital sample. These findings mean triple site testing could be expanded into women at no additional health service cost.

Abstract O019 Table 1 Sensitivity & specificity of separate and pooled samples

	Sensitivity (95% CI)	Specificity (95% CI)	PPV (95% CI)	NPV (95% CI)
NG separate samples	98.6 (90.2–99.7)	99.9 (99.5–100.0)	98.6 (92.6–100.0)	99.9 (99.5–100.0)
NG pooled	97.2 (90.2–99.7)	99.9 (99.5–100.0)	98.6 (92.3–100.0)	99.8 (99.4–100.0)
CT separate samples	99.1 (96.8–99.4)	99.7 (99.2–99.9)	98.7 (96.1–99.7)	99.8 (99.3–100.0)
CT pooled	95.5 (91.9–97.8)	99.5 (98.9–99.8)	97.7 (94.7–99.3)	99.0 (98.2–99.5)

There was no difference between self-taken samples analysed separately or pooled by McNemar test.