chlamydia and HSV). There were 2 new diagnoses of HIV at the time of GC diagnosis, and 2 further cases at 3 months follow-up.
Discussion/conclusion Management of rectal GC did not reach the BASHH targets on any recommendation, suggesting that improvements in managing rectal GC are needed within our clinic. Re-testing and re-attendance were poor. Staff has received further training and a re-audit in 2017 will assess improvement. We have established a robust call/recall system to enable early diagnosis of HIV which was significant in our cohort of men with rectal GC.

P168 CHEMSEX: A HEALTH NEEDS ASSESSMENT FOR AN EMERGING PUBLIC HEALTH CONCERN

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Background/introduction Reports of sexualised drug taking (chemsex) have increased significantly in recent years. To establish the risks associated with chemsex and the services required by participants in Greater Manchester, a health needs assessment was undertaken.
Aim(s)/objectives To identify links between chemsex and adverse health outcomes, and to determine the perceived barriers seeking support.
Methods An online survey was devised, and then promoted with the support of local voluntary organisations and sexual health clinics. Data were analysed on acute Hepatitis C diagnoses for the previous 5 years using data collected by PHE. Interviews were conducted with key stakeholders.
Results In total, 54 participants completed the anonymous online survey, of which 52 were men who have sex with men (MSM). 76% were HIV positive and 20% were Hepatitis C positive. The most commonly used recreational drugs were Mephedrone (81%) and GHB/GBL (79%). Of respondents, 78% felt they would prefer to access support in a specialist clinic within a sexual health service. Qualitative data on barriers to accessing support were determined. Using PHE Acute Hepatitis C data, 46% of the 57 patients diagnosed via Greater Manchester sexual health clinics between 2009 – 2015 had used at least one chemsex drugs in the past 12 months. Stakeholder interviews gave insight into perceived barriers to accessing care.
Discussion/conclusion We identify demographic factors of chemsex users and the perceived barriers to accessing support. These findings will be useful in guiding commissioning and tailoring specialist services.

P169 COMPARISON OF THE FTD™ URETHRITIS PLUS (7-PLEX) DETECTION KIT WITH ROUTINE SEXUAL HEALTH CLINIC NUCLEIC ACID AMPLIFICATION TESTING FOR DETECTION OF *NEISSERIA GONORRHOEAE* AND *CHLAMYDIA TRACHOMATIS* IN URINE, VAGINAL, PHARYNGEAL AND RECTAL SAMPLES

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Background/introduction The FTD™ Urethritis Plus (FTDU) nucleic acid amplification test (NAAT) detects seven pathogens associated with urethritis, including *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG), *Mycoplasma genitalium, Trichomonas vaginalis, Mycoplasma hominis, Ureaplasma urealyticum and Ureaplasma parvum*.
Aim(s)/objectives To perform an initial diagnostic evaluation of FTDU performance for NG and CT, compared to routine clinic NAAT (BD Viper), in prospectively collected genital samples from symptomatic patients.
Methods Alongside routine clinical samples, additional samples (n = 684) were taken from symptomatic patients: females (vulvovaginal swabs; VVS), men-who-have-sex-with-women (MSW) (urine) and men-who-have-sex-with-men (MSM) (rectal and pharyngeal swabs; urine).
Results The prevalence of CT was 9.38% across sample sites tested (24 Female, 21 Male, 3 MSM Urine, 1 MSM Pharynx and 5 MSM Rectal positives). The prevalence of NG was 9.74% across sample sites tested (5 Female, 6 Male, 10 MSM Urine, 17 MSM Pharynx and 19 MSM Rectal positives).
Discussion/conclusion FTDU was accurate for detecting CT from genital sites only and had poor sensitivity for NG at all sampling sites. This test could not be used for NG testing for urine or extra genital testing without supplementary testing according to the BASHH guidelines as the PPV is below 90%.

Abstract P169 Table 1 FTD™ Urethritis Plus (7-Plex) detection kit

	CT					NG				
Sample type (n)	**Females (287)**	**Males (98)**	**MSM Urine (56)**	**MSM Rectal (67)**	**MSM Pharynx (71)**	**Females (291)**	**Males (98)**	**MSM Urine (57)**	**MSM Rectal (67)**	**MSM Pharynx (72)**
Sensitivity%	100	100	66.7	21.9	50.0	80.0	83.3	50.0	78.9	64.7
(95% CI[a])	(85.7–100[b])	(83.2–100[b])	(9.4–99.2)	(14.7–94.7)	(1.3–98.7)	(28.4–99.5)	(35.9–99.6)	(18.7–81.3)	(54.4–93.9)	(38.3–85.8)
Specificity%	99.6	97.4	98.1	96.8	100	99.6	100	100	83.3	96.4
(95% CI[a])	(97.8–100.0)	(90.9–99.7)	(89.9–100)	(88.8–99.6)	(94.4–100[b])	(98.0–100.0)	(96.1–100[b])	(92.3–100[b])	(69.8–92.5)	(87.5–99.6)
PPV (97.5% CI[a])	96.0	91.3	66.7	21.9	100	80	100	100	65.2	84.6
	(79.6–99.9)	(71.9–98.9)	(9.4–99.2)	(14.8–94.7)	(2.5–100[b])	(28.4–99.5)	(47.8–100[b])	(47.8–100[b])	(42.7–83.6)	(54.6–98.1)
NPV (95% CI[a])	100	100	98.1	96.8	97.2	99.6	98.9	90.2	90.9	89.8
	(98.6–100[b])	(95.2–100[b])	(89.9–100)	(88.8–99.6)	(90.2–99.7)	(98.0–100.0)	(94.1–100)	(78.6–96.7)	(78.3–97.5)	(79.2–96.2)

[a]Binomial Exact
[b]one sided, 97.5% Confidence Interval

Further work is required to establish its suitability for detecting the other organisms claimed.

P170 RISK FACTORS FOR *MYCOPLASMA GENITALIUM* INFECTION IN SYMPTOMATIC MALES, FEMALES AND MEN WHO HAVE SEX WITH MEN FROM THREE CLINICAL SETTINGS IN LONDON

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Background/introduction *Mycoplasma genitalium* (MG), a sexually transmitted infection (STI), is increasingly recognised as a cause of major reproductive health sequelae. Treatment has become increasingly difficult due to macrolide and fluoroquinolone antibiotic resistance. MG is not routinely tested for in most UK genitourinary medicine (GUM) clinics, and limited risk-factor data exist for infection in at-risk populations and in different anatomical sites.

Aim(s)/objectives To determine risk factors for MG infection in symptomatic male and female patients accessing three London GUM clinics.

Methods Patients aged ≥16 years, symptomatic of an STI (or Chlamydia, Gonorrhoea, *Trichomonas vaginalis*, or non-specific urethritis contact) were consented. Additional-to-routine samples provided were vulvovaginal swab (VVS) (females), first void urine (FVU) (men-who-have-sex-with-women (MSW), (men-who-have-sex-with-men (MSM)), pharyngeal and rectal swabs (MSM). Samples were tested using the FTD Urethritis Plus Test kit and positives confirmed by Polymerase Chain Reaction. Risk factors were analysed using univariate and multivariate logistic regression.

Results MG was detected in: 10.7% (95% CI 7.9%–13.5%) patients; 7.9% (95% CI 4.86%–10.94%) VVS; 19.4% (95% CI 11.76%–27.04%) MSW urine; 1.6% (95% CI 0%–4.72%) MSM urine; 0% MSM pharynx; 8.1% (95% CI 1.31%–14.89%) MSM rectum.

Abstract P170 Table 1 Risk factors associated with MG infection

Risk	Male	Odds Ratios (95% Confidence interval) Univariate MSW	Odds Ratios (95% Confidence interval) Univariate Females
Age	16–19	1*	1*
	20–24	0.06 (0.01–0.61)	0.46 (0.15–1.40)
	25–34	0.16 (0.02–1.08)	0.26 (0.08–0.79)
	34–44	0.24 (0.03–2.03)	0.08 (0.01–0.68)
Ethnicity	White	1	1
	Mixed	10.00 (0.61–162.66)	2.98 (0.88–10.13)
	Asian	7.00 (0.46–96.44)	2.13 (0.24–18.76)
	Black	8.33 (1.78–38.97)	1.58 (0.60–4.19)
Symptoms	Discharge	1	-
	Pain	0.68 (0.24–1.89)	-
Gonorrhoea Contact	No	-	-
	Yes	-	11.5 (1.54–85.64)

*Only ages 16–19 remained a risk factor in the multivariate analysis

Discussion/conclusion MG positivity was highest in MSW compared to the other patient groups, with younger age being the only risk factor for infection, remaining after multivariate analysis. The presence of rectal MG despite a lack of urogenital infection in MSMs warrants further investigation with a larger cohort. Overall the results indicate high MG positivity across symptomatic male and female populations.

P171 RAPID RELIABLE HIV POINT OF CARE TESTING

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Background Our outreach HIV Point of care testing (POCT) programme changed from 4th generation testing to 3rd generation POCT kits in August 2014, which led to a significantly quicker turnaround time for results and greater convenience for both outreach staff and patients. We continued to confirm all POCT serology by conventional laboratory testing.

Aims To compare 3rd and 4th generation POCT in clinical practice and review the need for laboratory confirmation of all samples.

Methods The INSTI™ HIV-1/HIV-2 Antibody Test was used for POCT testing at a city centre outreach service from August 2014 until July 2015. All samples were also tested in parallel, in real-time, by standard laboratory tests for HIV. Results were compared retrospectively.

Results POCT was provided for 399 patients. 31 patients were excluded. Of the remaining 368 patients, there were 6 true positive results (1.6%) and no false-negatives or false-positives. By contrast, our previous evaluation of Alere Determine™ 4th generation testing, with a sample size of 367, found 3 true positives (0.8%); 2 false positives (0.6%); and 3 false negatives (0.8%), leading to negative predictive value 99.2%; positive predictive value 60%; sensitivity 50%; specificity 99.4%. This was a significant underperformance in clinical practice compared with advertised values.

Discussion INSTI™ is outperforming Alere Determine™ in our local experience. We intend to continue using 3rd generation POCT in our outreach programme. Given INSTI™'s performance, the question now raised is can we consider moving away from carrying out backup serology in all cases?

P172 HIGH HIV INCIDENCE IN MSM DIAGNOSED WITH EARLY SYPHILIS: A ROLE FOR PREP?

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Background. Understanding the risk factors for HIV acquisition allows targeted interventions to reduce HIV transmission such as PrEP.

Aims/Objectives. To evaluate HIV incidence in HIV-negative MSM with early syphilis infection.

Methods. A retrospective case-note review of MSM who were diagnosed with early syphilis between January and June 2014 at a London sexual health clinic.

Results. 206 MSM were diagnosed with early syphilis: 110 HIV-negative; 96 HIV-positive. For 110 HIV-negative MSM, median