GPs. The service opened in March 2014 as a monthly service (Friday 2–6 pm) and was provided by an experienced dual trained speciality doctor, band 6 nurse and band 2 technician together with the community nurse specialist for children with learning difficulties. The service provided STI/HIV screening and management, a full range of contraception choices and sexual health advice. New patient appointments were 1hr and involved time with both the Dr and nurse in order to meet the complex needs of the patients. After 14 months we relocated the service to our level 3 Sexual Health centre located on the main hospital site due to practical difficulties with providing a remote service to a complex group of patients. We changed the clinic session to a regular weekly session on a Wednesday afternoon (3–6 pm). From March 2014 to Dec 2015 there have been 60 attendances by 18 patients (13F, 5M; 17 heterosexual, 1 MSM; 90% white British). 50% patients were under 25 years with a range from 16 to 40 years. Number of STI screens: GC, chlamydia and HIV = 15; GC and chlamydia only = 10; HIV only = 3. STIs diagnosed: chlamydia = 3, TV = 1, PID = 2, 1st episode HSV = 1. Contraception services provided: implant 3, IUS 1, depo 2, COCP 2, EMC 2, PT 6. Historic child sexual abuse was disclosed by three patients.

Discussion/conclusion We successfully established a dedicated sexual health service for people with learning difficulties. Although numbers of attendances are small the patients present with complex needs and require long appointment times. 38% of our patients were diagnosed with an STI. The service team benefited from additional training in learning difficulties and capacity assessments and support from senior staff in the level 3 clinic.

P192 ACUTE HEPATITIS C INFECTION: ARE WE DOING ENOUGH?

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Background/introduction Hepatitis C (HCV) is an important blood-borne virus in the UK with high morbidity/mortality. Injecting drug use has traditionally been seen as the most important risk factor for transmission in Britain, but since 2000 there has been an emergent rise in infection rates amongst HIV-positive men who have sex with men (MSM). This is thought to be driven by risky sexual/drug taking behaviours.

Aim(s)/objectives Review viral response of acute HCV infections after treatment with current NICE approved therapy.

Methods A prospective case note review was performed of patients diagnosed with acute HCV between 2004–2015.

Abstract P192 Table 1 Data for acute HCV treated within 6 months of diagnosis

Response	SVR	No SVR	Predictive value(%)
RVR	4	0	PPV = 100
No RVR	7	1	NPV = 12.5
EVR	6	1	PPV = 85.7
No EVR	1	0	NPV = 0

RVR = Rapid viral response, EVR = Early viral response, SVR = Sustained viral response, PPV = Positive predictive value, NPV = Negative predictive value.

Results There were 102 acute HCV infections. Median age 37, (range 20–61), all cases were male and MSM. 91 (89%) patients had Genotype 1 infection, and 98 (96%) were co-infected with HIV. 36 (35%) patients had a history of injecting drug use. 20 patients were initiated on pegylated interferon/ribavirin within 6 months of diagnosis.

Discussion/conclusion Only 4 (20%) acute HCV patients achieved simultaneous RVR/SVR within 6 months of diagnosis (PPV = 100%). Novel direct acting antivirals (DAAs) have SVR rates above 90%; this alone is a compelling reason to promote DAAs in managing the burden of HCV infection thus reducing propensity for onward transmission.

P193 MANAGEMENT OF PATIENTS WITH HIV AND HEPATITIS C CO-INFECTION AT A SMALL TEACHING HOSPITAL; AN AUDIT AGAINST 2013 BHIVA GUIDELINES

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Background/introduction HIV positive patients with Hepatitis C (HCV) progress to cirrhosis faster than patients without HIV. BHIVA guidelines 2013 recommend surveillance for cirrhosis and hepatocellular carcinoma.

Aim(s)/objectives To evaluate the management of patients with HCV and HIV co-infection against current guidelines for surveillance for liver disease, including with Liver Transient Elastography (TE).

Methods The clinical records of all patients with HIV and HCV co-infection in the last 10 years were reviewed.

Results 41 patients had co-infection; 6 patients spontaneously cleared HCV. 100% (41/41) of all new diagnoses of HCV received HCV RNA measurement. Genotyping carried out in 86% (30/35) of patients and not possible in 6 cases. Annual HCV RNA was carried out in 76% (29/38). Only 8% (3/36) cases had initial TE result. In 17/36 the result was not recorded, and there was no evidence that the TE had been carried out. In 14/36 the patient did not attend the tertiary centre. Two of the initial TEs were reported as normal (less than 7 kPa). For annual TE assessments, 5/36 were reported.

Discussion/conclusion Most patients reviewed did not have assessment for liver disease per national guidelines. Our monitoring of patients with HCV and HIV co-infection particularly with liver TE is poor. The main barrier to co-infected patients receiving care is non-attendance at the tertiary centre. The Trust is now a "spoke" in a hepatitis C network and has local TE, which may improve monitoring of co-infected patients. We will re-audit after this programme has been running for one year.

P194 SEXUALLY TRANSMITTED INFECTION (STI) SCREENING IN MEN WHO HAVE SEX WITH MEN (MSM)

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Background/introduction MSM are at increased STI risk. Easily accessible and thorough STI screening should be available to all MSM. BASHH recommendations for MSM STI screening include guidance about which tests to offer and to whom, and suggested frequency of testing.