and only routinely taken from men who have sex with men (MSM). Recent studies suggest that gonorrhoea and chlamydia infections are being missed by taking vulvovaginal and urethral samples only. Therefore, it was decided to take throat swabs for chlamydia and gonorrhoea from all patients aged 20 and under that attended the dedicated Young Persons' Clinic for one year. The findings so far will be presented here.

Results A total of 225 YPC attendees had a throat swab taken between April 2016 and February 2017. Twenty-five out of 225 patients (11%) were found to have pharyngeal chlamydia or gonorrhoea. Five patients had pharyngeal chlamydia and twenty had pharyngeal gonorrhoea. A significant number, fourteen of the twenty-five (56%), had pharyngeal chlamydia or gonorrhoea only with no genital infection. Gonorrhoea was detected in twenty patients' throats and chlamydia in five. Pharyngeal cultures were taken from eleven out of the twenty gonorrhoea patients, three of which were macrolide resistant and two macrolide intermediate.

Discussion Prior to the study throat swabs were not routinely being taken from heterosexual patients. More than half of patients with pharyngeal infection had no genital infection and would not have received treatment under the current clinic guidelines. These are significant findings which may lead to a change in practice in the service.

P014 DOES SEPARATION OF HIV AND SEXUAL HEALTH SERVICES AFFECT THE MANAGEMENT OF STIS IN PEOPLE LIVING WITH HIV?

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Introduction The presence of a bacterial STI increases the risk of HIV transmission. It is important that people living with HIV have easy access to STI treatment and that partner notification is robust. In our local area, HIV care is located and commissioned separately from the sexual health service. Does this affect STI treatment and partner notification?

Methods All HIV positive patients with a diagnosis of gonorrhoea, Chlamydia or new/infectious syphilis during 2015 were identified from laboratory results and computer records. Demographic details for each patient were recorded and the management of their STI assessed according to BASHH standards.

Abstract P014 Table 1 Impact of separation of HIV and sexual health services

Infection	Number of patients	Mean interval between test and informing patient (days)	Mean interval between informing patient and attendance for treatment (days)	Mean number of partners attending within 4 weeks [BASHH standard]
Gonorrhoea	24	14.6	4.5	0.375 [0.6]
Chlamydia	23	13.3	4.8	0.348 [0.6]
Syphilis	16	22.6	40.2	0.125 [0.4]

Results

Discussion Barriers to timely treatment included difficulty contacting patients, need to travel to a different service to obtain medication and difficulty arranging appointments at acceptable times. Particular delays were noted in the management of syphilis. Clarification of each service's responsibilities with regard to contact tracing could improve partner notification rates. Even when HIV and sexual health services are not jointly commissioned, it is essential that both departments work together to develop robust pathways for the management of STIs identified in people living with HIV.

P015 RECEIVING 1G AZITHROMYCIN AS PART OF MASS DRUG ADMINISTRATION (MDA) FOR THE CONTROL OF TRACHOMA IS ASSOCIATED WITH REDUCED GENITAL MYCOPLASMA GENITALIUMPREVALENCE

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Introduction Mass Drug Administration (MDA) with 1g oral azithromycin for ocular *Chlamydia trachomatis* (CT) infection, a key component of trachoma control, can concomitantly reduce genital CT prevalence. However, this dose is known to be sub-optimal for the treatment of genital *Mycoplasma genitalium* (MG) infection. Here we investigate factors associated with MG infection in pre- and post-MDA sample sets.

Methods Pre-MDA (T1) and 6 months post-MDA (T2) CT-negative self-collected vulvo-vaginal swabs from women attending three outpatient antenatal clinics (Honiara, Solomon Islands), were tested for MG infection using nucleic acid amplification. Logistic regression was used to determine factors associated with infection. Variables tested included: patient age, clinic attended, ethnicity, time spent in education, living in an urban or rural environment, marital status, living with spouse, presence of symptoms associated with a sexually transmitted infection (STI), having an STI in the last 12 months, current CT, Gonorrhoea or *Trichomonas vaginalis* infection, and at T2 only receipt of MDA dose.

Results MG positivity was found in 11.9% (95%CI: 8.3–16.6; 28/236) of women at T1 and in 10.9% (95%CI: 7.7–15.4; 28/256) at T2 (p=0.7467). The only factor associated with having an MG infection was history of not having received MDA with azithromycin at T2 (odds ratio 0.19, 95%CI 0.07–0.53, p=0.001).

Discussion Not having MG infection was associated with receiving 1g azithromycin as part of MDA for trachoma control six months previously. However there was no overall drop in population prevalence, indicating individual but not population benefits of MDA with regard to MG infection control.

P016 CLINICAL UTILITY OF A MYCOPLASMA GENITALIUM (MG) REFERRAL DETECTION ASSAY IN SELECTED SEXUAL HEALTH CLINIC ATTENDEES

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Introduction Routine testing for MG in the UK is limited by a lack of assays. New assays are becoming available, with many detecting antimicrobial resistance. We reviewed our use of an MG PCR test, and our treatment of MG, to inform a new, broader testing strategy.
Methods The clinical database was interrogated for all MG requests from November 2016-February 2017. Data collected: demographics, indication, test result, and treatment.
Results 85 samples were sent from 81 individuals: 79 (93%) were male, [39 (49%) MSM]. Indications for testing were: dysuria +/- discharge in 63 (74%), testicular/pelvic pain in 11 (13%), test of cure in 5 (6%), and contacts of infection in 3 (4%). 88% were tested on the second or greater attendance and 22 (26%) had already had received at least two antimicrobial treatments.

18/85 tests (21%) were positive for MG, of whom 17 (94%) had persistent or recurrent urethral discharge +/- dysuria. The remaining case was a female contact of recurrent NGU. Of the 17, 15 (88%) had previously been treated for NGU with azithromycin 1g (6, 40%) or doxycycline (5, 29%) or both (4, 24%). Eleven (61%) were treated with extended azithromycin (despite 5, (45%) having received azithromycin 1g already) and 4 (22%) with moxifloxacin.
Discussion Testing for MG in our service is performed mainly in men with persistent/recurrent NGU. Prevalence of MG in this selected group was high. Despite the likelihood of resistance, many patients received repeat courses of macrolides. Earlier testing for MG may reduce time with symptoms and improve antimicrobial prescribing behaviour.

P017 MANAGING MYCOPLASMA GENITALIUM IN CLINIC: DON'T FORGET THE PARTNERS

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Introduction There is increasing UK interest in Mycoplasma genitalium(MG) testing of clinic attendees where indicated. Partner notification(PN) is a crucial part of STI management but as yet no national performance standards specific to MG have been defined.
Methods Case note review of all MG cases at our clinic from December 2015 to November 2016. Data collected on the four PN outcomes outlined in the 2012 BASHH statement on PN for STIs.
Results 114 cases were identified. Mean age 28.5, 82(71.9%) male of whom 36(43.9%) MSM. The proportion of cases with a PN discussion documented (83.3% [95% CI 75.2–89.6]) and the proportion of cases with an outcome of agreed contact action(s) documented (78.1% [95% CI 69.4–85.3]) were both lower than the national standard of 97.0% ($p<0.0001$).

There were 0.22 (95% CI 0.17–0.28) contacts per index case whose attendance at a sexual health service for treatment was reported by the index case and 0.19 (95% CI 0.14–0.24) contacts per index case in which a healthcare worker verified treatment. Performance was lower than the national standard of 0.60($p<0.0001$), and inferior to local chlamydial and gonorrhoeal PN data, 0.6 and 0.5 contacts per index case reported treated respectively. Performance across all PN outcomes was worse for men than for women.
Discussion PN for MG at our clinic falls below local and national standards for other STIs. Contributory factors may include poor documentation, absence of national guidance for MG PN performance standards and lack of patients' appreciation of the importance of MG as an STI.

P018 UNIVERSAL TREATMENT – SHOULD WE REVIEW?

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Introduction Guidelines recommend epidemiological treatment of patients presenting as a contact of infection. This potentially reduces the prevalence of infection, reducing infectivity and reduces patient visits. Over prescription of antibiotics poses a threat of future resistance development and exposes the patient to unnecessary treatment. An audit was carried out to determine if any themes could be identified to indicate a likely positive result in contacts.
Methods We audited asymptomatic contacts of chlamydia and gonorrhoea (PNC/PNG) attending GU services at BartsHealth (February 2016 for 3 months). Data on gender, sexual orientation, contacts (regular or casual), infection site, time since sex with contact, HIV status, STI in previous year were collected. Testing by Aptima NAATS for chlamydia/gonorrhoea and gonorrhoea culture.
Results
Chlamydia 75 asymptomatic contacts (55 male/20 female). All treated as contacts. 25 had a positive result (34%). No factors could be associated with predicting a positive result, except a suggestion that a regular partner v casual partner. Gonorrhoea: 85 asymptomatic contacts (76 male/9 female). All treated as contacts. 27 had a positive result (32%). Being male >24years old/MSM/>5 partners (in 3m) and contact being a regular partner were suggestive of predicting a positive result.
Discussion The audit reinforces epidemiological treatment. Drawbacks of not treating include failure to return, onward STI transmission and inconvenience of re-attending. However, over 60% had potentially unnecessary treatment and with rapid turnaround of results (<2d), future universal treatment may need to be revised.

P019 ARE GPS TREATING GONORRHOEA APPROPRIATELY?

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Introduction Gonorrhoea continues to develop progressive antibiotic resistance. It is essential 1st line therapy is used wherever possible (intramuscular ceftriaxone with azithromycin 1g). GPs make an important contribution to gonorrhoea diagnosis and treatment (~5% of all diagnoses, of which ~40% are treated by GPs, 10% with recommended therapy).
Methods To assess local practice, the department of microbiology provided a database of all the cases of gonorrhoea diagnosed across our city Jan 15–Dec16. We reviewed cases diagnosed in primary care.