

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.