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.

Results 1.7% (34/1,956) of all gonorrhoea cases were diagnosed in primary care. Median age 32 (range 18-66); 18 male, 16 female. 88% (30/34) were registered with sexual health (SH); 19 (56%) had attended for the management of episode in question (two of these had prior treatment with azithromycin 1g, or azithromycin/cefixime). Of the remaining 15 cases:

Abstract P019 Table 1 Are GPs treating gonorrhoea appropriately?

1st line therapy	Treated in primary care	2
	Referred and treated in level 2 service	2
Non-1st line therapy	Oral cefixime 400 mg + azithromycin 1 g stat	2
	Treated empirically at 1st visit (azithromycin 1g); advised level 3 but DNA	3
	Treated empirically at 1st visit (doxycycline 1 week);advised level 3, DNA	1
Advised to attend level 2/3 services – no record/DNA		3
2 no further information (1 surgery had closed)		2

100% of patients not receiving 1st line therapy had 'referral to SH advised' documented in the notes.

Discussion Knowledge of correct gonorrhoea management pathways was high. Oral cefixime/azithromycin is no longer recommended 1st line, however cure can be achieved at an individual level. It is likely some patients without record of attendance visited other services outside our area. The high number of female patients compared with our usual male to female ratio (10:1) raises doubts about false positive results in a low prevalence female population.

P020 COMPARISON OF THE APTIMA MYCOPLASMA GENITALIUM TMA ASSAY AND THE FASTTRACK DIAGNOSTICS (FTD) URETHRITIS BASIC ASSAY FOR DETECTION OF M. GENITALIUM IN GUM SPECIMENS

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Introduction Testing for *M. genitalium* in the UK is limited and detection has relied on realtime PCR assays. The Hologic Aptima *Mycoplasma genitalium* TMA assay for use on the Panther® system is now available. This study compared a commercial realtime PCR and the Aptima assay using stored clinical specimens.
Methods Clinical specimens (76 urines, 33 vaginal swabs, 2 rectal swabs, 1 pooled sample and 2 unknowns) from men with urethritis and women with pelvic inflammatory disease were tested for *M. genitalium* DNA using the FastTrack Diagnostics (FTD) Urethritis Basic assay. Residual specimen was then transferred to an Aptima urine tube and tested for the presence of *M. genitalium* ribosomal RNA using the Aptima TMA assay.
Results Of the 113 specimens tested, 24 (21%) were positive and 87 (77%) negative on both assays. There were two discrepant results (1.7%) in urine specimens that were positive on the Aptima TMA assay and negative on the FTD Urethritis assay. One was confirmed as positive by the Reference Laboratory using their in-house MgPa PCR, indicating a false negative result on the FTD Urethritis assay. The other discrepant result was low level positive on the Aptima TMA assay and negative at the Reference Laboratory.
Discussion 98% of samples gave concordant results, indicating that both assays are appropriate for use in clinical service. However, the additional positive detected by the Aptima assay, explained by detection of target in multiple copies in each bacterial cell, suggests that this assay is more sensitive.

P021 MYCOPLASMA GENITALIUM- TESTING AND TREATING IN A LEVEL 2 PRIMARY CARE SERVICE

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Introduction Mycoplasma genitalium (MG) is an emerging sexually transmitted infection causing up to 20% cases of urethritis in men and is a cause of PID. Most UK centres do not have access to MG testing. Locally we use an algorithm for testing and management of MG in collaboration with our level 3 service screening men with urethritis and women with PID.
Methods We reviewed the electronic Patient records of patients tested for MG from January 2016 to February 2017.
Results 66 patients were screened, all with genital symptoms. 35(53%) were male. 10/66(15.2%) patients tested positive for MG, 6(9.1%) males and 4(6.1%) females: median age was 34. The clinical symptoms were: 4/66(6.1%) -penile discharge, 4/66(6.1%)-long history of increased vaginal discharge, 1/66 (1.5%)-haematospermia, 1/66(1.5%) penile sores. 8/10(80%) were treated with 1st-line treatment (extended course of Azithromycin) in our primary care service while 2/10(20%) were referred to Level 3 service for assessment and treatment. Partner notification was done and documented in 50% of the positive cases but interestingly none of the 10 patients attended for test-of-care as advised.
Discussion We have shown that MG testing and treatment is feasible in a level 2 primary care setting in collaboration with level 3 services and that MG prevalence is high in symptomatic patients using this service.

P022 PHARYNGEAL GC: MAINTAINING STANDARDS IN MANAGING A SILENT INFECTION

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Introduction Our local area has the UK's highest prevalence of gonorrhoea. Pharyngeal infection is commonly asymptomatic, thereby acting as a reservoir of undiagnosed infection. Development of antimicrobial resistance continues to be a challenge to preserving sensitivity to current first-line treatment. Aim: To assess the management of pharyngeal gonorrhoea at an inner city sexual health centre with reference to BASHH 2011 guidelines.