

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?

1 st line therapy	Treated in primary care	2
	Referred and treated in level 2 service	2
Non-1 st line therapy	Oral cefixime 400 mg + azithromycin 1 g stat	2
	Treated empirically at 1 st visit (azithromycin 1g); advised level 3 but DNA	3
	Treated empirically at 1 st 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 1 st 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.