

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.

Methods All cases of positive pharyngeal NAATs dating from 1st July 2014, to 1st August 2016, were identified from the clinical records portal and a case-note review completed.

Results 219 cases were included in the final data analysis - median age 33 (range 19–58). 131/219 (60%) lone pharyngeal gonorrhoea cases were identified. 194/219 (95%) were MSM. 89/131 (67%) pharyngeal cultures were obtained: (16%) positive for *Neisseria gonorrhoea* – 9/16 demonstrated some antimicrobial resistance. Only 8/131 (6%) had a sore throat documented at screening. 205/219 (94%) received treatments in clinic (14 patients lost to follow up). Of those treated 113/205 (55%) received a test of cure with 100% negative NAATs. All patients receiving 2nd line treatments were clinically justified. 1 patient was diagnosed HIV+ within 6 months of pharyngeal gonorrhoea treatment.

Discussion The majority of infections were asymptomatic (94%) demonstrating validity of on-going triple site screening. The low sensitivity of positive pharyngeal *N.gonorrhoea* cultures (16%) reinforces importance of pharyngeal NAATs for detection of infection and review of culture sampling techniques. A low rate of TOC reflected the difficulties in completing patient follow up seen in our clinic population

P023 INVESTIGATING THE CLINICAL VALUE OF *TREPONEMA PALLIDUM* PCR WITHIN A UK GUM CLINIC

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Introduction Syphilis is a multistage STI caused by *Treponema pallidum*. The classic lesion of primary syphilis is a chancre – a single, painless, indurated ulcer with a clean base. The number of cases is on the rise, and it has been historically difficult to diagnose due to its variable presentation, requiring clinical correlation and multiple investigations. PCR use has increased recently in investigation of these ulcers. However, how crucial is PCR testing in primary syphilis, when cheaper investigations can lead to a diagnosis?

Methods Investigation results were collected from 58 patients presenting between January and December 2015 who were treated for primary syphilis, including presentation, serology and PCR status. How they were diagnosed as having primary syphilis was noted and whether this was on presentation, follow up or via PCR.

Results 47 patients had a positive PCR, 11 patients had a negative PCR but were treated for primary syphilis. We found 3 patients would have not been picked up as having primary syphilis if there was no PCR performed. The sensitivity and specificity of *Treponema pallidum* PCR was 81% and 100% respectively.

Discussion PCR was essential in diagnosing 3 patients with syphilis who would have been missed, therefore PCR is a crucial tool in contributing to the diagnosis of primary syphilis. The potential implications of missing syphilis diagnosis are serious, as patients can develop progressive disease and unknowingly affect sexual partners.

P024 REDUCING REPEATED CHLAMYDIA AND GONORRHOEA INFECTIONS

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Introduction The role of Sexual Health Services (SHS) is not only to treat sexually transmitted infections (STIs) but also to reduce repeat infection through appropriate antimicrobials, health education and partner notification (PN). We reviewed the management of patients with repeat infections.

Methods A retrospective case-note review of patients attending the SHS with more than one episode of chlamydia and/or gonorrhoea, July 2015 – June 2016.

Results 156 patients were identified of which a random sample of 30 (20%) were reviewed. All were male; median age 29.5 (range 21–58). 70% (21) were MSM, 23% (7) heterosexual, 7% (2) bisexual. 30% (9) were HIV positive. Risk-factors for unsafe sex (e.g. substance misuse/sex-work/mental-health diagnosis) were noted in 77% (23). 77% (23) had 2 infective episodes; 23% (7) had 3 episodes. Of the 67 infective episodes all were treated appropriately; 40% (27) were treated the same day, 9% (6) within 1-week, 24% (16) within 2-weeks, and 22% (15) within 2–4 weeks. Patients reported 1–100 partners in the 6-months prior to review. 73% (48) saw a health advisor (HA); in the remaining 28% the most common reason for not seeing a HA was being managed in non-sexual health clinics e.g. PEP/HIV-research/general HIV. PN was undertaken in 82% (55) of episodes although only completed in 52% (35) largely due to untraceable partners.

Discussion Focusing on addressing risk factors for unsafe sex may facilitate a reduction in repeat STIs. While most patients were able to access HA support, referral pathways from non-SHS clinics need improving. PN remains challenging in the context of multiple casual partners and novel strategies such as electronic PN should be urgently explored.

P025 ACCURATE CULTURES FOR GONORRHOEA. HOW DO COMMUNITY SERVICES AND SECONDARY CARE COMPARE?

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Introduction BASHH guidelines emphasise the importance of accurate cultures in the diagnosis and management of gonorrhoea. This audit's aim was to establish if there was a measurable difference in the positive culture yield between community and secondary care services in the months following a change in contract which has moved a proportion of walk in patients from secondary care to the community setting.

Methods Relevant databases were searched for gonorrhoea patients after 1st October 2017 when the service was changed. A retrospective audit of the notes was then carried out to establish the rates of positive NAATs tests and positive culture yield and compared the two services.