Methods A retrospective analysis of medical records of patients attending the local GUC with a diagnosis of syphilis from 2002–2015 was carried out. Data concerning patient demographics (age, gender and sexual orientation), year of diagnosis, syphilis stage, treatment regime, HIV/STIs co-infections, partner notification and follow up were recorded.

Data collected was inputted in an excel database.

Results In the study period a total of 291 patients were diagnosed with syphilis. 82.6% were males (n=238); 48.6%(n=143) were MSM and 5.2% (n=5) bisexual men. Syphilis was diagnosed in the primary stage in 11.3% of patients, secondary in 9.6%, early latent in 30.9% and late latent in 47.4%. All patients with syphilis were tested for HIV and 16.1% (n=147) resulted HIV positive, 74.5% of them (n=35) were MSM. Partner notification was not possible and/or not reported in 40.5% (n=118) of patients. In 21% (n=61) of cases, it was not possible to establish whether the treatment was successful because these were lost to follow up.

Discussion As the syphilis rates continue to rise so rapidly, it is very important to have robust mechanisms in place to limit spread such as proactive recall for treatment and follow up and education and support regarding safer sexual practices.

P032 CHARACTERISTICS OF A HIGH SYPHILIS INCIDENCE COHORT IN AN INNER-CITY LONDON CLINIC

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Introduction Syphilis cases continue to increase in London. We aimed to investigate the characteristics and risk factors of patients diagnosed with syphilis at our centre.

Methods Retrospective case note analysis of all syphilis cases diagnosed in our sexual health clinic in 2016.

Results 56 cases were identified; mean age was 42 (range 16–69 years), with 80% male. The two commonest ethnicities were Black Caribbean (20%) and White Other (20%). 18% were HIV positive, and 18% had concomitant STIs, with one new HIV diagnosis. 26% had been treated for syphilis previously.

Just under a third of patients were symptomatic, the rest being identified through routine screening in clinic or through online testing. Just over a fifth of the cases (12/56) were primary syphilis, with secondary syphilis diagnosed in 7% of patients. All primary and secondary syphilis cases occurred in MSM, and there was a correlation with reported chemsex, with 38% prevalence.

Two of the patients were vulnerable, one being a vulnerable child aged 16. One of the patients was on PREP.

There were 21 cases in heterosexual patients, all were late latent syphilis. Heterosexual men were older (mean 50 years); most heterosexual patients came from regions with high syphilis rates and endemic treponematoses.

Discussion There is high ongoing transmission of syphilis in MSM in our cohort, linked to risky sexual practices and drug use. Increased awareness of syphilis symptoms might facilitate earlier presentation to clinics. As many patients were asymptomatic, there is a pressing need for regular screening in high risk groups.

P033 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEAE

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Introduction We present a retrospective analysis of clinic performance in the 5 domains of management and treatment of Neisseria gonorrhoeae (GC) according to current British Association of Sexual Health and HIV (BASHH) guidelines.

Methods All cases of GC diagnosed at our clinic between 1st January and 30th June 2016 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared with data from the same clinic for the same six months (1st January to 30th June) in 2007-2015.

Results 87% of patients treated for GC were recommended to have a test of cure (TOC) (61% had a TOC.). 100% of with GC were screened for Chlamydia trachomatis or received presumptive treatment for this. 88% of patients with GC had partner notification carried out. 56% of patient's received written information about GC. 97% of patients with GC received 1st line treatment, or the reason for not doing so was documented.

Discussion We have demonstrated consistent improvement in 2 of the 5 domains compared with previous years' data. Recommending a test of cure, partner notification and offering patient information leaflets have decreased over the last year. To address this, teaching sessions were carried out and a quality improvement project to ensure patient information leaflets are offered is underway.

Further staff training and awareness of management of N. gonorrhoeae will be addressed on a regular basis and a re-audit is recommended next year.

P034 ASSOCIATION OF MYCOPLASMA GENITALIUM AND PERSISTENT ABDOMINAL PAIN- WHAT SRH DOCTORS UNDERTAKING ULTRASOUND NEED TO KNOW?

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Introduction The 2016 European guideline on Mycoplasma Genitalium (MG) states that significant association is found between MG and pelvic inflammatory disease (PID). MG is diagnosed through nucleic acid amplification testing. The aim of this study was to find out about the importance of testing for MG in patients with persistent abdominal pain.

Methods It was a retrospective analysis of patients who were tested for MG in Sexual and Reproductive healthcare (SRH) consultant ultrasound clinic over a period of 17 months. The inclusion criterion for testing was persistent symptoms after PID treatment.

Results 9 patients were tested for MG in consultant led SRH ultrasound clinic. All were initially treated by other clinicians for PID with standard treatment but did not respond and were referred to SRH ultrasound clinic to exclude other pathology. Ultrasound for all of the patients was normal with no adnexal masses or free fluid. Pregnancy test was done in all cases and it was negative; all patients were also negative for chlamydia and Gonorrhoea. MG testing was done in all 9

cases and 2 came back positive (22%). Both were treated with Moxifloxacin 400mg OD for 10 days.
Discussion This small study shows that there can be an association between persistent abdominal pain and MG. SRH doctors who are undertaking ultrasound on a routine basis should consider possibility of MG testing in patients with persistent abdominal pain. More research is needed in this area to establish a routine testing for MG in a patient with abdominal pain.

Contraception and Reproductive Health

P035 QUICK STARTING HORMONAL CONTRACEPTION AFTER USING ORAL EMERGENCY CONTRACEPTION: A SYSTEMATIC REVIEW

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Introduction Unprotected intercourse after oral emergency contraception (EC) significantly increases pregnancy risk. This underlies the importance of promptly starting effective, ongoing contraception – known as 'quick starting.' However, theoretical concern exists that quick starting might interact with EC or hormonal contraception (HC) potentially causing adverse side effects.
Methods A systematic review was conducted, evaluating quick starting HC after oral EC (levonorgestrel 1.5mg [LNG] or ulipristal acetate 30mg [UPA]). PubMed, EMBASE, The Cochrane Library, ICTRP, ClinicalTrials.gov and relevant reference lists were searched in February 2016. A lack of comparable studies prevented meta-analysis.
Results Three randomised controlled trials were identified. Two biomedical studies suggested HC action was unaffected by quick starting after UPA; one study examined ovarian quiescence (OR: 1.27; 95% CI 0.51 to 3.18) while taking combined oral contraception (COC). Another assessed cervical mucus impenetrability (OR: 0.76; 95% CI 0.27 to 2.13) while taking progestogen-only pills (POP). Quick starting POP reduced the ability of UPA to delay ovulation (OR: 0.04; 95% CI 0.01 to 0.37). Side effects (OR: 1.22; 95% CI 0.48 to 3.12) and unscheduled bleeding (OR: 0.53; 95% CI 0.16 to 1.81) were unaffected by quick starting COC after UPA. Another study reported higher self-reported contraceptive use at eight weeks among women quick starting POP after LNG, compared with women given LNG alone (OR: 6.73; 95% CI 2.14 to 21.20).
Discussion Limited evidence suggests quick starting HC after UPA does not reduce HC efficacy, however it reduces UPA efficacy. Consequently, women should delay starting HC after UPA.

P036 IMPROVING LARC UPTAKE: A RETROSPECTIVE STUDY INTO THE ROLE AND IMPACT OF ENHANCED SEXUAL HEALTH SERVICES IN COMMUNITY PHARMACIES

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Introduction Unwanted pregnancies and low uptake of LARC continues to be problematic in 15–44 year olds in an East London Borough. Between April 15 and March 16, 45 pharmacies were commissioned, as part of the local enhanced sexual health service (LES) to provide emergency hormonal contraception (EHC) and contraception advice with the aim of increasing LARC uptake in <25s and others at high risk of unwanted pregnancy. Pharmacies taking part in the pilot received PGD and safeguarding training and pathways into LARC were refreshed.
Methods Analysis of self-sample STI tests via the Doctor's Laboratory and consultations documented via PharmOutcomes, and corresponding search of PreView for attendances for contraceptive/LARC care during time period.
Results 35/45 pharmacies (77.8%) dispensed 324 Levonorgestrel (1500 microgram) doses to women resident in the borough >13 years (average age 24.9 years; range 14.2-49.6 years). 100% of <16s had Fraser competency assessed (4). 6.2% (20/324) women had >1 attendance for EHC. 16 women (4.9%) subsequently attended local CaSH/GUM services for LARC; 8 (2.5%) for implant; 4 (1.2%) for injectable; 4 (1.2%) for IUD.
Discussion Pharmacy delivered EHC and signposting to LARC services in primary and secondary care is feasible. There were limitations in the ability to gather data regarding women accessing LARC in primary care following contact with pharmacy so these numbers may under report the actual figures of those accepting LARC following pharmacy contact. Online booking systems should be accessible to pharmacists to facilitate LARC referral. Further work looking at acceptability of this strategy should be conducted.

P037 WHY DO WOMEN DISCONTINUE LONG ACTING REVERSIBLE METHODS OF CONTRACEPTION? – FINDINGS FROM AN INTEGRATED SEXUAL HEALTH CLINIC

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Introduction Long acting methods of contraception, namely the progestogen only implant and the intra-uterine devices are reliable methods of contraception, favoured by commissioners of integrated sexual health. However in practice, a number of women discontinue these for a variety of reasons thus leading to reduced cost effectiveness. We aimed to determine the number of discontinuations among those who had them fitted in the integrated sexual health clinic and the reasons for doing so.
Methods Retrospective analysis of the case notes on the electronic database for all women who had an implant, copper intra-uterine device or the Mirena intra-uterine device during September 2014 was collected. Reasons noted by the clinician for removing the device and any adjuvant therapy that was prescribed was noted.
Results A total of 183 women had one of the three methods fitted during this period. Of these 36% had them removed after a median of 2.16 years. Of those who had the implant fitted, 49% had them removed after a median of 1.84 years. Vaginal bleeding was quoted as the reason for removal in 51% of the women. Of the 25% of the women who had the