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

Mirena IUD removed, vaginal bleeding was the reason in 44%. Variety of reasons were noted among the 36% of women who had copper IUD fitted.

Discussion Our findings has shown that vaginal bleeding was the predominant reason for discontinuation for the implant and Mirena IUD. This has shown that appropriate management of irregular vaginal bleeding may lead to longer retention of long acting methods of contraception.

P038 ULTRASOUND SCANNING IN GUM CLINICS – IS IT FEASIBLE; IS IT VALUABLE?

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Introduction With increasing financial constraint and commissioning pressures, GUM providers need to develop services to improve clinical care and cut costs. In order to provide fully integrated sexual health provision we introduced trans-vaginal ultrasound scanning to assess IUD/IUS position and placement as well as scanning for deep implants in August 2016 at a central London clinic.

Methods A member of staff trained in ultrasound was identified and a suitable portable machine sourced. From 11th August 2016, the new service was advertised to clinics within the trust and patients could be referred for assessment of coil/implant presence and position both for booked 'sessions' and on an ad hoc basis.

Results To 3rd March 2017, 127 TV scans have been performed. The indication for scanning was: 70 (55%) post insertion of inter-uterine contraception; 21 (17%) for lost threads; 9 (7%) bleeding problems and 27 (21%) other reasons.

5% (6/127) devices were identified as incorrectly positioned and could be changed at the scanning appointment. Only 1 patient required onward referral for a departmental ultrasound scan.

Discussion Ultrasound scanning in GUM clinics is feasible and has proven to be a valuable addition to current services offered. Consequently referrals for hospital based ultrasound scans have decreased, resulting in shorter waiting times for patients as well as providing a 'one stop shop' for patients.

P039 USER EXPERIENCE OF ONLINE BOOKING TOOL FOR LARC APPOINTMENTS

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Introduction Timely access to contraceptive counselling and increased use of LARCs is recognised as the key to avoid unintended pregnancy. In line with national SRH strategy, we aimed to improve access to LARC by supporting women to make informed choices and reducing barriers. The Sexual Health hub includes access to sexual health, well-being and contraception information, with positive promotion of LARCs, in one accessible site. Delivering pre-LARC counselling through online videos enables women to attend for a single focussed LARC fitting appointment.

Methods We recorded a number of metrics to assess uptake and impact on service provision and surveyed users to assess acceptability.

Results In the first 5 months we saw:

151% increase in visits to LARC self-help content and use of pre-consultation videos

11% of available bookable appointments made online, the majority out of hours

10% reduction in call volumes to services

Improved patient experience and choice as evidenced through user survey

- Very easy or easy to book an appointment online: 84%.
- Very easy or easy to find information and advice online: 92%
- Very likely or likely to recommend to a friend: 96%
- Very likely or likely to use the website again: 95%
- Positive free text comments

Discussion Our experience to date shows this approach is well received by patients who appreciate the flexibility it offers in their busy lives. It has also delivered efficiencies in administrative time, releasing staff for other tasks. We are monitoring the impact on uptake of LARC and anticipate data will further support this approach.

P040 MANAGING WOMEN REQUESTING PROGESTOGEN ONLY IMPLANT IN AN INTEGRATED SEXUAL HEALTH CLINIC

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Introduction The progestogen only contraceptive implant is widely recognised as a reliable and cost-effective form of contraception. However, there is evidence to suggest that irregular or unpredictable bleeding is responsible for 60% of implant removals and another complication being that of deep implants. Continuous low-dose progestogen predisposes to breakthrough bleeding because uterine blood vessels proliferate and become disordered, with a 'leaky' basement membrane. The best approach is to provide oestrogen, usually in the form of the combined oral contraceptive pill (COC). We aimed to determine the proportion of women who have documented evidence of a palpable implant at the time of insertion and the proportion of eligible women with unscheduled bleeding offered the COC.

Methods A retrospective case note review was performed on the electronic database for the period between 1 July 2016 and 31 January 2017. First 100 women who requested implant fitting and the first 100 women who requested implant removal due to unscheduled bleeding were recruited.

Results Of the 100 women who had an implant fitted, 24% requested re-fitting. Palpable implants were documented in 76% of women. This was not documented in 24% of women, all of whom had another implant re-fitted. Of the eligible 100 women who requested removal for unscheduled bleeding and had no contra-indication for COC, only 49% had the offer of COC documented.

Discussion This review has shown the need to improve documentation of implant palpation and to offer COC to eligible women which will reduce unnecessary early removals, thus