Methods We looked at cases of hepatitis C diagnosed in our sexual health/HIV service per calendar year from 2012 – 2016 and looked at HIV status, injecting drug use and sexual behaviour.
Results We saw 37,012 attendances for sexually transmitted infection testing by MSM in the study period: There were 9 diagnoses of hepatitis C in HIV negative MSM in the study period. (2012:3, 2013:3, 2014:1, 2015:2, 2016:0). 5/9 HIV negative MSM diagnosed with hepatitis C gave a history of IDU. 4/9 HIV negative MSM diagnosed with (incident) Hepatitis C had no documented history of IDU, all had a recent history of condom-less anal sex at chem-sex parties; 2/4 had engaged in fisting and none were using PrEP at the time of diagnosis.
Discussion There appears to be a very small amount of hepatitis C transmission in HIV negative MSM who do not inject drugs associated with condom-less anal sex at chem-sex parties and fisting. Screening for hepatitis C could be rationalised to these groups of MSM.

O07 NATIONAL RESPONSE TO AN OUTBREAK OF HEPATITIS A ASSOCIATED WITH MEN WHO HAVE SEX WITH MEN IN ENGLAND, 2016/2017

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Introduction Hepatitis A virus (HAV) is a vaccine-preventable infection, mainly travel-associated in the UK. Since July 2016 Public Health England has detected an increase in hepatitis A laboratory notifications in men who have sex with men (MSM). We described the outbreak characteristics to inform implementation of nation-wide control measures.
Methods A confirmed case was defined as a HAV infection with one of three outbreak strains and symptom onset after 31//6/16. Demographics, travel history and sexual behaviours were collected using a questionnaire.
Results By February 2017, 73 confirmed cases were detected across England. Of these 58 identified as MSM (median age 36 years) and 28 reported travel within the incubation period, primarily to Spain. 25% reported >1 casual partner in the previous 8 weeks. In addition to supporting the local public health response, PHE collaborated with national STI, HIV and liver associations to refine immunisation recommendations for at-risk MSM and alert front-line clinicians, and worked with the NHS and sexual health charities to raise awareness and promote personal hygiene and immunisation among MSM via social media, posters and leaflets.
Discussion The outbreak is likely associated with other MSM outbreaks with the same strains in other UK and European countries. The investigation suggests initial multiple importations from abroad followed by secondary sexual transmission within the MSM population in England. This outbreak highlights the need for MSM and healthcare professionals to consider the potential of HAV as a sexually transmitted infection, and the need to consider immunisation of MSMs where recommended.

O08 HPV 16 AND 18 SEROPOSITIVITY AND DNA DETECTION AMONG MEN WHO HAVE SEX WITH MEN: EVIDENCE FOR THE POTENTIAL BENEFIT OF VACCINATION

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Introduction To estimate the prevalence of antibodies to HPV16 and HPV18, and genital HPV DNA among MSM attending a London sexual health clinic, to inform the potential benefit of vaccination in a high risk population.
Methods A cross-sectional study of 18-40 year-old MSM including a computer-assisted self-interview for behavioural data, and collection of extra-genital and intra-anal swabs, and blood. Anogenital samples were tested for 21 genotypes of HPV DNA using an in-house assay. Blood samples were tested for anti-HPV16 and HPV18 IgG by ELISA.
Results 496 MSM were included: among HIV negative MSM, HPV16 seroprevalence was 27% (95%CI 23–31) and HPV18 was 16% (13–20); HPV16 and 18 DNA prevalence 12.6% (9.8–15.9) and 6.0% (4.0–8.5) respectively. In HIV-positive MSM, seroprevalence was 58% (95% CI 37–77) and 35% (95%CI 17–56), and DNA prevalence 29.6% (13.8–50.2) and 11.1% (2.4–29.2) respectively.

After adjusting for age and lifetime partners, seropositivity for anti-HPV–16 and/or HPV–18 was associated with: HIV-positive diagnosis (HPV16-aOR: 3.16 [95%CI 1.37–7.28]), receptive anal sex in the last three months (HPV16-aOR: 3.39 [2.01–5.71]; HPV18-aOR: 2.14 [1.18–3.90]), use of drugs anally (HPV18-aOR: 2.07 [1.05–4.10]) and anogenital same-type DNA detection (HPV16 aOR: 3.58 [2.05–6.23]; HPV18 aOR:2.71 [1.17–6.27]).
Discussion Anogenital HPV DNA detection was less frequent than, but strongly associated with same-type HPV seropositivity. Most MSM attending a sexual health clinic had no serological or DNA evidence of exposure to HPV infection. This supports the case for the potential benefit of targeted HPV vaccination of MSM attending sexual health clinics, as currently being piloted in England.

O09 THE IMPACT OF AN HPV VACCINATION PROGRAMME IN YOUNG MEN WHO HAVE SEX WITH MEN (MSM) ON CLINICAL PRESENTATIONS WITH GENITAL WARTS

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Introduction We introduced a quadrivalent HPV (HPV4) vaccination programme in young MSM <27yrs attending our clinical services (Clinic 1 & 2) since 2012. We assess the impact on attendance with genital warts (GW) subsequent to vaccination in this population and an adjoining service (Clinic 3) not then offering vaccination.