Methods We identified all MSM <27yrs receiving at least one dose HPV4 at Clinics 1 & 2, and all MSM <27yrs attending Clinic 3, between 2012 and 2017. Demographic and clinical data was extracted from electronic patient records. HPV DNA testing was not performed.

Abstract O09 Table 1 Clinical Outcomes in HPV4 vaccinated and unvaccinated MSM under 27yrs

Characteristic	Clinic 1& 2 HPV programme No./Total (%)	Clinic 3 No HPV programme No./Total (%)	Probability value p =
History of prior/current GW	75/757 (9.9%)	27/180 (9.6%)	p = 0.06
Ever Re-attended	524/757 (69%)	81/180 (45%)	p = 0.0001
Subsequent episode of GW: Re-attenders	11/524 (2%)	22/81 (27%)	p = 0.0001
Subsequent episode of GW: All	11/757 (1.5%)	22/180 (12%)	p = 0.0001
New cases of GW	3/757 (0.4%)	4/180 (2%)	p = 0.0285

Results Current or prior history of GW was comparable in the 2 clinic populations. Re-attendance rates were lower in the clinic without active recall. Recurrent episodes of GW was higher 22/180 (12%) in the unvaccinated population than the vaccinated group 11/757 (1.5%). Incidence of new cases of GW, defined as a first clinical episode > 3 months since 1st vaccine, was significantly lower in the vaccinated population.
Discussion We observed a significant reduction in subsequent episodes and potential new episodes of GW in an unselected population of MSM receiving HPV4 vaccine. Significant clinical benefit and saving can be expected from an HPV4 programme in MSM.

O10 AETIOLOGY OF AND TRENDS IN ANOGENITAL HERPES DIAGNOSES IN ENGLAND FROM 2006–2015

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Introduction Anogenital herpes (AH), associated with significant physical and psychological morbidity, is the second most commonly diagnosed viral sexually transmitted infection (STI) in England and is caused by infection with Herpes Simplex Virus (HSV) Type-1 or Type-2. We investigated the epidemiological and serotype characteristics of AH diagnoses in England and changes over time.
Methods We performed a descriptive analysis of socio-demographic and clinical characteristics of AH using data from the national surveillance system for STIs (GUMCADv2), and calculated the proportion of new episodes by serotype using data from the national laboratory surveillance system in England from 2006–2015.
Results There were 31,312 first and 25,356 recurrent AH episodes in 2015, and diagnosis rates of first episode AH increased 55% from 38 to 59 per 100,000 population since 2006. In 2015, diagnosis rates were highest among women (73.5), people aged 20-24 (243.1), those of Black Caribbean ethnicity (176.3), and London residents (93.8). Although MSM only accounted for 4.6% (n=1430) of diagnoses in 2015, there was an 18% increase in diagnoses since 2011; overall 28% of MSM diagnosed with AH were HIV-positive. The distribution of HSV-1/HSV-2 has remained stable since 2006: in 2015, 48% of women and 36% of men with AH were diagnosed with HSV-1 infection.
Discussion Increased diagnoses of AH may be due to changes in sexual practices or improved test sensitivity. Differences by socio-demographic characteristics can be used to inform prevention strategies, while those by serotype are essential for guiding vaccine development.

O11 USING A PROFESSIONAL PATIENT MYSTERY SHOP TO EVALUATE MANAGEMENT OF RECENTLY DIAGNOSED HSV-2, COMPARED WITH DATA FROM A NATIONAL QUESTIONNAIRE

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Introduction In 2014, the British Association of Sexual Health and HIV updated guidelines detailing the expected management of Anogenital Herpes type 2 (HSV-2). This study aims to evaluate counselling given to patients with HSV-2 and determine how clinicians are dealing with sensitive topics that arise during these consultations.
Methods 210 UK Genito-Urinary Medicine (GUM) clinics were sent an anonymous questionnaire, the results of which were analysed and compared with current guidelines. A pilot mystery shopping study, involving a patient with a reported recent HSV-2 diagnosis, was performed in 3 UK GUM Clinics. Details of each consultation were graded as A (acceptable), U (unacceptable) or C (a cause for concern) by a panel of 6 experts.
Results Analysis of the returned questionnaires showed inconsistencies in answers between clinicians and guidelines. The advice given during the visits was graded 69.7% A, 16.8% C and 13.5% U. Staff performed well with providing emotional support and guiding patients to extra materials (84.5% A) but did significantly less well on topics such as disclosure (65.9% A, p=0.0025), transmission (71.8% A, p=0.032) and pregnancy (53.9% A, p=0.000013) (Pearson's Chi-squared test).
Discussion The study has exposed some short falls in clinical practice, which should be addressed by future guidelines and education events at BASHH, should they be supported by a larger-scale study. Returning anonymised data to participating clinics may allow them to deal with discrepancies in their practice.

O12 LGV TESTING: ARE WE IDENTIFYING ALL CASES IN A TIMELY MANNER?

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Introduction BASHH recommends *Lymphogranuloma venereum* (LGV) testing of *Chlamydia trachomatis* (CT)-positive specimens from men who have sex with men (MSM) presenting with proctitis, and all rectal CT from HIV-positive MSM. Until recently in England, LGV testing was only available as a referred test at the Sexually Transmitted Bacteria Reference Unit (STBRU). In July 2016 we implemented a validated in-house version of the STBRU LGV PCR on all CT-positive specimens from MSM, regardless of symptoms or HIV status. We assessed the time from specimen collection to result (turn-around time, TRT) and defined clinical features of LGV cases.
Methods From July 2016 to March 2017 we reviewed all positive LGV tests, recording patients' demographics, HIV status, chemsex behaviour, presence of symptoms and LGV result TRT.
Results We conducted 587 LGV tests on CT-positive specimens from MSM, of which 50 (8.5%) were positive. Median age of LGV cases was 38 (range 23 to 65), 28 (56%) were Caucasian, 38 (76%) were HIV positive and chemsex behaviour was reported by 20 (40%); 12 patients (24%) had a past history of LGV. Nine (18%) cases were asymptomatic and three of these were HIV-negative MSM. The mean TRT was 12 days (range 8 to 20); compared with 35 days (range 15 to 118) in the six months prior to in-house testing.
Discussion LGV continues to occur mainly in HIV-positive MSM as symptomatic proctitis. Testing all CT-positive MSM increased detection of LGV compared with following BASHH guidelines, and in-house testing reduced TRT significantly.

O13 'I WAS STRUGGLING TO FEEL INTIMATE, THE DRUGS JUST HELPED'. CHEMSEX AND HIV-RISK AMONG MEN WHO HAVE SEX WITH MEN (MSM) IN THE UK: SYNDEMICS OF STIGMA, MINORITY-STRESS, MALADAPTIVE COPING AND RISK ENVIRONMENTS

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Introduction There has been a steep rise in the use of drugs during sex by some men who have sex with men (MSM), with associated increases in sexual risk for HIV and other STIs. This 'Chemsex' has been described, but there is a lack of theoretical perspectives applied to this particular phenomenon.

We aimed to assess participants' reasoning and conceptualisation of Chemsex and situate this within theoretical frameworks.
Methods This study presents data from telephone interviews with 15 MSM attending sexual health clinics following a risk of HIV and accessing post-exposure prophylaxis (PEP). Interviews were conducted as part of a larger interventional study, which used an adapted version of Motivational Interviewing to explore risk behaviour and support change. We used Framework analysis on interview transcripts in order to understand participants' perspectives on the use of chemsex.
Results Participants conceptualised their chemsex and HIV risks in their psycho-social context, highlighting the influence of the psycho-socio-cultural challenges of homophobic marginalisation and the 'gay scene' on their behaviour. Narratives of loneliness and difficulties in forming satisfying social and sexual relationships were repeatedly identified.
Discussion Multiple influences of stigma, minority stress and maladaptive coping (including drug-use) are seen to contribute to syndemic 'risk-environments' in which chemsex and risk behaviours are played out. Interventions to address the harms of chemsex must recognise the complex psychosocial context of risk, and shift the responsibility for change from vulnerable individuals to a shared responsibility distributed across social, political and institutional contexts.

O14 CHEMSEX, CONSENT AND THE RISE IN SEXUAL ASSAULT

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Introduction Within the chemsex population reports of sexual assault, non-consensual sex and coercion are rising. We looked at consent among our chemsex clinic users.
Methods Retrospective data review of patients from April 2015 to March 2017. Data was collected on sexual assault, coercion, exploitation, risk taking, sexually transmitted infections and drug use.
Results 72 men were seen with a median age of 32. 41 (56.9%) were HIV positive, and 11 (15.3%) had Hepatitis C. 53 (73.6%) patients used Mephedrone, 40 (55.6%) GHB and 22 (30.6%) Crystal Meth. 13 (18.1%) patients reported self-harm. In total 23 (31.9%) patients reported non-consensual sex. A minority 5/30 (16.7%) were identified from April 2015 to Jan 2016 when using the terminology 'forced into sex'. After realising that addressing consent is more complex in this cohort, we prioritised consent discussions around unwanted sexual attention and from Jan 2016 to March 2017 18/42 (42.9%) reported non-consensual sex (Table 1).

Abstract O14 Table 1 Chemsex

Assault/coercion	N/42 (%)
Non-consensual sex	18 (42.9%)
Reported as sexual assault	6 (14.3%)
Coercive sex	4 (9.5%)
Sex while unconscious	3 (7.1%)
Assaulted > once	2 (4.8%)
Allegations of organised assault	2 (4.8%)
Injected/filmed while unconscious	1 (2.4%)

Discussion Our data shows rates of non-consensual sex among chemsex users of up to 42.9%. There is a lack of patient understanding around what sexual assault and consent are and exploring this in a sensitive manner is paramount. Sexual assault discussions must be reviewed in both standard sexual health and chemsex clinics.

O15 A SERVICE EVALUATION COMPARING HOME-BASED TESTING TO CLINIC-BASED TESTING FOR CHLAMYDIA AND GONORRHOEA IN BIRMINGHAM AND SOLIHULL

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