Discussion The audit has shown that the addition of HSV swabs and treatment into the guideline had a positive effect, with more cases of HSV proctitis being diagnosed and treated. Our guidelines were also modified to include LGV treatment, but given the low prevalence this may be rationalised. Ongoing work around coding is also planned as many were coded as proctitis without rectal microscopy.

P109 ROUTINE HEPATITIS C ANTIBODY TESTING IN MSM – ARE WE OVERTESTING?

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Introduction The hepatitis C virus (HCV) is rarely transmitted sexually. MSM with HIV are at increased transmission risk. Debate exists regarding sexual transmissibility of HCV in those without HIV or additional risk factors beyond receptive anal intercourse. Following outbreaks of HCV in Europe and London in MSM, Oxfordshire Sexual Health Services introduced annual unselected HCV antibody testing as a screening minimum for all MSM. Evidence now suggests this may not be necessary. We set out to audit our HCV testing to assess this and identify potential policy modification.
Methods We reviewed all HCV antibody tests undertaken in a 12 month period. We identified all HCV positive patients to determine risk factors for infection in order to establish whether these patients were identified through annual screening or would have been identified using a selective basic risk analysis.
Results We found 13 positive results out of 1351 tests. 6 had previously known HCV, 4 were co-infected with HIV. 2 were heterosexual men with additional risk factors, one was an MSM with additional risk factors. No HIV negative MSM with HCV infection were identified through annual screening alone. Approximately 3.5% of tests undertaken were based on recognised risk factors for HCV, 96.5% were undertaken as part of annual screening. This equated to £1486 per new diagnosis, excluding service costs.
Discussion Routine annual screening of HIV negative MSM in this study did not pick up any new HCV diagnoses. Cost per diagnosis may be reduced with targeted testing. The annual screening policy needs modification.

P110 WORKING SMARTER BY INCORPORATING ONLINE TESTING: MAXIMISING SELF-MANAGEMENT OR OPENING AN ADDITIONAL CHANNEL? A TWELVE MONTH REVIEW

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Introduction We reviewed how the introduction of online access to sexually transmitted infection (STI) testing for a county wide sexual health service has affected face to face (F2F) attendances, and overall attendance numbers.
Methods As part of managing a large county wide integrated-sexual health service we have based our planned attendance numbers on actual activity data from previous years to forecast service activity. In April 2016 we introduced the option of online STI access alongside a complementing triage system. Using electronic record and online access data we compared actual to projected activity, and established the effect of the online service in terms of overall activity for 2016/17.
Results The introduction of an online channel together with a reviewed triage system appears to have directly reduced F2F attendances. The overall activity level including both F2F and online for the service did rise, but based on the cost of F2F attendance compared with theaverage cost of online tests, there are still estimated savings of over £500,000 and predicted reduction of around 10,000 F2F attendances.

Abstract P110 Table 1 F2F and Online testing

Service	Activity plan 2016–17	Activity actual 2016–17 (based on quarters 2 and 3 extrapolated)
F2F	59410	49398
Online access	4654	17118
Total	64064	66516

Discussion People have been satisfied with the online service and it appears to be an acceptable and popular alternative and not and addition to F2F. The reduction in F2F attendances (10,000) frees up clinical time enabling improved and increased resource for complex care and staff and service development.

P111 REACHING OUT – GUM IN THE GENERAL PRACTICE SETTING

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Introduction Providing accessible GU services in rural areas is difficult. Providing a service in General Practice (GP), close to patients' homes may increase access (particularly to those who might not otherwise test) and avoid the perceived stigma of attending a GUM clinic. A GUM service was set up in 2008 within a general practice setting (syndromic management), in an area of high need (HIV prevalence 2.58 PHE 2015).We aim to describe the outcomes of running a GU clinic within GP.
Methods Demographic, attendance and diagnoses data was collected and analysed from 2008–2016.
Results A total of 1081 patients were seen (1826 attendances) with a median of 200(186–221) per year. 604 diagnoses of infection were made (33.1%). 922(85%) lived in the town where the clinic was held. 53.8%(582) had never been seen in GU in our county before compared with 32.6% in the hubs. 440 (41%) were men of which 40(9%) were MSM. Mean age for attendees was 29 (28 at the main GU hub). Total number <20 year olds fell from 2007-2016 but those aged 21–35yrs and 45–60yrs increased. Table 1 shows the distribution of GUMCAD diagnoses. There were 426 DNAs (18.9%), 42% were follow-ups. Overall HIV testing was refused in 15.5% cases, (30% in 2007 but 7% in 2016).

Discussion In rural areas where transport links are limited, a GU clinic run in GP offers an efficient, anonymous service. Services can be offered in this setting with few extra resources providing an alternative point of access for patients.

Abstract P111 Table 1 GUM in general Practice

Diagnosis	n=604	% all diagnoses	% all patients	% attendances
Chlamydia	190	31.4%	**17.5%**	10.4%
Gonorrhoea	7	1.2%	0.6%	0.4%
Syphilis	1	0.2%	0.09%	0.05%
HIV	1	0.2%	0.09%	0.05%
Other	406	67.0%	37.6%	22.2%

P112 RETROSPECTIVE STUDY OF THE RESULTS OF TAKING OF BLIND SWABS VERSUS SPECULUM-ASSISTED SWABS IN WOMEN WITH VAGINAL DISCHARGE

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Introduction Although a speculum is generally recommended to aid the taking of swabs for microscopy in women with vaginal discharge, many women dislike this and ask for a blind swab, in which a plastic loop is inserted high into the vagina to take a sample. We have agreed to this for some women and have therefore retrospectively looked at the diagnostic rates for each method.
Methods We looked at 150 consecutive women clinically coded as 'TS' (microscopy performed) in 2015 and 2016 and looked at the proportion of women tested by each method and the vaginal-discharge-causing infections diagnosed.
Results In 2015, 129 women had clear documentation of the method used of which 120 (93%) where speculum-taken and 9 (7%) were 'blind'. In 2016, of 101 women with documentation of the method used 52 (51%) were speculum-taken and 49 (49%) were 'blind'. The diagnostic rates for each infection are given in the table.

Abstract P112 Table 1 Blind.v. speculum testing

Method used to take sample	Total number of women tested by each method	TV	BV	Candida	BV + Candida
Blind	58	3 (5%)	18 (31%)	9 (16%) *	0**
Speculum	172	8 (5%)	75 (44%)	58 (34%)*	24**

* P=0.008 ** P=0.0001

Discussion The blind swab method appears to be accurate in the diagnosis of TV and possible BV, but is clearly inferior in the diagnosis of candida and mixed candida/BV infections.

P113 DOMESTIC VIOLENCE – DO WE ASK? WILL THEY TELL?

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10.1136/sextrans-2017-053232.157

Introduction Experience of domestic violence is reported as 28.3% in women and 14.7% in men. It causes significant harm and screening sexual health clinic attendees is recommended. Proformas used within our service include a question on domestic violence however screening practice among clinicians varies.
Aim Investigate the prevalence of domestic violence among our clinic attendees and determine if current practice is successful at identifying this.
Methods Patients attending a clinic on 9th January 2017 were asked to complete an anonymous questionnaire including questions on domestic violence, mental health, unplanned pregnancy and STI's. A retrospective audit of documentation of domestic violence in patient's records was then undertaken for all patients attended on that day.
Results Total number of attendees on 9th January was 111, 57 completed questionnaires (52% female and 50% male attendees). Domestic violence was reported by 27% female attendees and 16% male attendees (10% in heterosexual male, 33% in MSM). Females suffering domestic violence more commonly reported sexual assault, mental health problems and unwanted pregnancy.

34% female attendees had a documented enquiry regarding domestic violence. 24% of these reported domestic violence. Among male attendees 38% had a documented enquiry with 9% reporting domestic violence. Reporting of domestic violence by men to clinicians was lower than predicted by the survey.
Discussion With our current practice we can expect to miss 10 women and 5 men a day who have suffered domestic violence. Routine enquiry is to be recommended. Reluctance to disclose domestic violence may still be a barrier to identifying this hidden problem.

P114 SENSITIVITY AND COST-EFFECTIVENESS OF TRICHOMONAS VAGINALIS NAAT (NUCLEIC ACID AMPLIFICATION) ASSAY IN SYMPTOMATIC FEMALE PATIENTS ATTENDING A GENITOURINARY MEDICINE CLINIC

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Introduction Trichomonas vaginalis is the commonest curable sexually transmitted infection worldwide. Diagnosis is by detecting Trichomonas organisms or its DNA. Sensitivity of microscopy in females is 45–60%. Culture has a higher sensitivity than microscopy but molecular detection offers the highest sensitivity and is considered gold standard. We currently use only microscopy and this may lead to false negatives. This study assesses sensitivity and cost-effectiveness of TV NAAT assay compared with microscopy and acridine orange (AO) staining in symptomatic female patients.
Methods Prospective study looking at symptomatic female patients attending sexual health clinic during the period from 05/10/2015 to 17/05/2016.Female patients with one or more of the following symptoms; vulval soreness, itchiness, ulceration or abnormal discharge were included. Wet microscopy was performed and dried slide was sent to the lab for AO staining. TV NAAT was added to the Chlamydia/Gonorrhoea dual testing swab.