P178 TRAUMATIC RECTO-VAGINAL FISTULA AFTER CONSENSUAL SEXUAL ACTIVITY: A CASE SERIES

Kathryn Waite*, Claire Webster, Sharad Karandikar, Doug Bowley.

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Introduction Consensual vaginal intercourse may be associated with relatively minor genital injury, such as mucosal abrasions, tears or ecchymoses. More severe genital injury is more likely to be associated with rape or sexual assault by penetration with an object. Conversely, we know that the absence of genital injury does not mean that rape or serious sexual assault did not occur.
Methods We report a small series of patients presenting with severe and life-threatening genital injury after consensual sexual activity.
Results An adult woman presented with lower abdominal pain and faeculent vaginal discharge after sexual activity with her intimate partner involving consensual and simultaneous insertion of two sex toys (one *per rectum* and another *per vaginam*). She had sustained a 100mm defect in the posterior vaginal and antero-lateral rectal walls. Despite surgery and faecal diversion, she developed severe sepsis that required extended critical care.

A second patient presented with faeculent discharge *per vaginam* after consensual, 'conventional' peno-vaginal intercourse. On examination, she was found to have a 30 × 20 mm low recto-vaginal fistula; on this occasion not associated with peritoneal contamination or serious septic response.
Discussion Traumatic recto-vaginal fistulae are rare with implications for both immediate morbidity and mortality and long-term physical and mental well-being. These cases demonstrate the extreme spectrum of genital injury that may be associated with consensual sexual activity. Recognition that this severity of injury can occur following consensual activity is important and our first patient's story also highlights some of the public health implications concerning the use and regulation of sex toys.

P179 ERECTILE DYSFUNCTION CLINIC: EXPLORING DRIVERS AND BARRIERS TO SEEKING HELP

Stephen Megarity*, Wallace Dinsmore, Laura Bell, Emma McCarty. *Royal Victoria Hospital, Belfast, UK*

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Introduction Erectile dysfunction (ED) may affect up to half of men in their lifetime. Barriers can prevent discussion of symptoms with their GP and on occasions they will present at GUM clinics. Understanding these barriers can be useful in assessing their experiences and expectations of treatment.
Methods Anonymous self-administered questionnaire issued to new patients attending ED clinic. The Sexual Health Inventory for Men (SHIM) score used to classify ED severity.
Results 75 patients with median age of 52 years (range 19–78 years) participated. 93% had significant co-morbidities or vascular risk factors. In regard to SHIM, 47% classified as severe ED, 16% moderate, 26% mild-moderate and 11% mild. Duration of ED prior to attendance was greater than 5 years in 53% of patients. 50% reported significant impact on quality of life and notably 40% had underlying depression and/or anxiety. Seeking treatment was important/very important in 96%. Relationship difficulties prompted 65% patients to seek help. Barriers to seeking treatment included embarrassment in 47% and lack of treatment awareness in 29%. Initial discussion about ED was prompted by the patient in 85%. Regarding support, 73% discussed the issue with their partner and 16% with a friend/relative. 7% self-sourced treatment prior to attendance. The majority of patients (88%) reported limited knowledge of ED with 77% suggesting patient information leaflets would be useful prior to clinic attendance.
Discussion Patients presenting with ED often delay seeking advice. Medical comorbidities, relationship difficulties and embarrassment are significant issues affecting patients which should be taken into consideration during consultations.

P180 UNUSUAL CAUSES OF GENITAL ULCERATION PRESENTING TO GENITOURINARY MEDICINE CLINIC – A CASE SERIES

Emma Kinghan*, Stephen Megarity, Emma McCarty.

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Introduction Genital ulceration presents frequently at GUM clinics, with herpes simplex (HSV) infection a common aetiology. A diagnosis of HSV is distressing with possible implications for relationships and future pregnancies. It is therefore important to consider other causes if atypical presentation or negative HSV PCR from area of active ulceration.
Method Case review of uncommon aetiologies of ulceration.
Results Case 1: 25 year old. Prodromal sore throat and flu-like symptoms. Examination revealed deep ulcers on vulva and oral mucosa without eye or skin involvement. CRP 120, ESR 80, ASOT titre 400, negative autoimmune screen, monospot negative. Developed anterior uveitis and erythema nodosum 24 hours later. Diagnosed with Behcet's disease requiring prednisolone and mycophenolate mofitil.

Case 2: 28 year old. Prodromal sore throat and headache. Sexual history atypical for HSV. Known Graves' disease, on propylthiouracil. On examination, patient looked unwell. Shallow vulval ulceration noted. Neutrophils 0.1, ESR 31. Diagnosed with apthous ulceration secondary to neutropenia and admitted for neutropenic-sepsis treatment. Required thyroidectomy with pathology revealing papillary carcinoma.

Case 3: 13 year old referred by SARC. No history of sexual contact or features of child sexual exploitation. Prodromal flu-like illness. Of note, mother Influenza A positive.

No response to empirical acyclovir. HSV PCR negative. Nasopharyngeal swab confirmed Influenza A. Case subsequently closed with SARC and Social Services.
Discussion This case series highlights less common but important causes of genital ulceration. Full systemic history and clinical assessment remains essential in those where alternate diagnoses to HSV are being considered.

P181 IS PROMOTION OF BLOOD DONATION IN THE GU CLINIC ALL IN VEIN?

Clare Wood, Cara Saxon*, Sameena Ahmad. *Department of Sexual Medicine and HIV, University Hospitals of South Manchester NHS Foundation Trust, Manchester, UK*

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Introduction In the UK less than 3% of the population donate blood. The blood donation service faces a constant challenge

of recruiting new donors and stocks remain at critically low levels.

The histories we take in genitourinary (GU) clinics match closely with screening questions asked by the donation service and we wanted to explore whether there would be any value in utilising this similarity in promoting blood donation to our often young and otherwise healthy patient population.

Methods We conducted a prospective review of 100 consecutive patients seen during clinic, adding one extra question (regarding recent travel) to our usual history proforma to match the screening questions.

Results Of the 100 patients 25 (25%) would never be able to donate blood (18 sexually active men who have sex with men (including 4 with HIV), 6 with precluding health conditions, 1 ex-intravenous drug user). There were 13 (13%) not eligible to donate blood for up to 12 months (9 'high risk' sexual contact in last 12 months, 2 travel related, 1 pregnant, 1 on PEP post needlestick). Of these and the remaining eligible patients (62%), only 18 (24%) have donated (or attempted donation) previously.

Discussion We may not think of a GU clinic as a location to identify blood donors, however we found that 75% of the patients seen were potentially eligible. No additional time was needed to identify potential donors and only a brief intervention or posters in the clinic could be used to promote or signpost blood donation.

P182 CHLAMYDIA POSITIVE TESTING TO TREATMENT TURNAROUND TIME (TAT) APRIL TO DECEMBER 2016

Gordon Proctor*, Liat Sarner, Merle Symonds. *Barts Health NHS Trust, London, UK*

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Introduction Reduction in time to treatment for those with STIs is key for reducing negative sequelae, identifying and treating STIs in partners and preventing onward transmission. BASHH 2014 Standards stipulate that results should be available within 10 working days of testing but there are no standards published for time from test to treatment. In our service patients are told to access results after 7 days. Our results management team contact untreated patients 7 days after testing.

Aims To ascertain the time period between STI test date, availability of result and receipt of treatment for those testing positive for chlamydia within a large multi-site service.

Methods A retrospective audit of the sexual health service electronic patient record (EPR) was undertaken from April to December 2016 identifying all chlamydia positive results across our service. Date of test, availability of result and treatment received was analysed. The following data was analysed.

Results 2897 patient records were identified for analysis. 550 were excluded due to incomplete data. 2347 records were analysed. 63.9% of results were available in 72 hours (mean 48 hours) and 96.2% in 7 days. 51.7% were treated within 48 hours of result availability, 56% within 7 days, 92.2% within 14 days and 97.5% by 28 days.

Discussion The majority of results are available within 72 hours however <60% of patients were treated within 5 days. Patients will now be advised to access the results within 3 days and the service will contact untreated patients within 5 days of a positive result.

P183 RETROSPECTIVE ANALYSIS OF THE UTILISATION OF SCROTAL ULTRASOUND SCAN IN SEXUAL HEALTH CLINIC

Malaki Ramogi. *Colchester Hospital University NHS Foundation Trust, Colchester, UK*

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Introduction Most scrotal/testicular symptoms and signs are benign. US Scan is investigation of choice in these patients. However, several studies have shown ultrasound scan findings rarely changes management of these patients. Our aim was to understand how ultrasound scan influenced the diagnosis and management of men with scrotal or testicular symptoms seen in our sexual health clinic.

Methods Retrospective data collected from clinical records of all men seen in sexual health clinic and referred for US scan between 2010 and 2016. Data collected include age, presenting symptoms, STI screen, clinical and ultrasound finding.

166 men had ultrasound scan. 23 men excluded due to incomplete data. Data collected and analysed for 143 men.

Results Median age was 33 years (range 15 – 72 years). Common scrotal/testicular symptoms were: lump 72 (50%), aches/pain 45 (31.5%), others 15 (10.5%). Ultrasound scan diagnoses were: Benign epididymal or tunica albuginea cyst 40 (28%), Varicocele 25 (17.5%), Hydrocele 15 (10.5%), Normal 34 (24%), other 26 (18%), Cancers (testicular 2 and sarcoma 1) (2%). 7 men were referred to urologist for cancer treatment and embolization of varicocele.

Discussion Most men had benign scrotal conditions or normal findings confirmed on scan. This did not change their management plan. Two cases of testicular cancers were initially suspected on clinical examination.

P184 ADHERENCE TO PCP PROPHYLAXIS GUIDELINES IN HIV POSITIVE PATIENTS

Jessie Drake*, Mathew Cunningham, Yvonne Gilleece. *Brighton and Sussex University Hospital NHS Trust, Brighton, East Sussex, UK*

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Introduction Pneumocystis Pneumonia (PCP) prophylaxis is often continued despite acceptable CD4 counts in HIV positive individuals on antiretroviral (ARV) treatment. Both BHIVA and EACS guidelines advise discontinuing prophylaxis if the CD4 count is >200 cells/mm3 for 3 months, EACS additionally states that prophylaxis should be stopped if the patient has a CD4 count of 100-200 and an undetectable Viral Load (VL) for 3 months.

Methods We analysed the case notes of all individuals actively receiving Co-trimoxazole prophylaxis prescriptions, and assessed clinical details, CD4 count and VL data to decide whether their continued prescription was in accordance with current guidelines.

Results We identified 32 patients, 27 male, currently on Co-trimoxazole prophylaxis. 18 individuals (56%) met the criteria for continuing PCP prophylaxis. Of the remaining 14, 3 individuals were on immunosuppressive medications for co-morbidities, and were therefore appropriately receiving prophylaxis. 11 of 32 individuals (34%) were found to be receiving Co-trimoxazole despite meeting guidance for discontinuing prophylaxis. 8 of these patients met the BHIVA guidelines, while an additional 3 met the EACS guidelines.