P206 PREVALENCE AND RISK FACTORS ASSOCIATED WITH CHLAMYDIA TRACHOMATIS (CT), MYCOPLASMA GENITALIUM (MG) AND NEISSERIA GONORRHOEAE (NG): CROSS-SECTIONAL STUDY IN THREE SEXUAL HEALTH CLINICS

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Introduction *Chlamydia trachomatis* (CT), *Mycoplasma genitalium* (MG), and *Neisseria gonorrhoeae* (NG) infections contribute to major reproductive health sequelae. CT and NG are routinely tested for in sexual health clinics (SHCs), whereas MG is not. Population prevalence estimates for males and females for CT and MG are >1% and <0.1% for NG infection. Risk factor data, which help target control interventions, are limited in men-who-have-sex-with-men (MSM). We assessed prevalence and risk factor data in symptomatic patients accessing SHCs.

Methods Patients aged ≥16 years with symptoms of an STI provided: vulvovaginal swabs (females), first void urine (men-who-have-sex-with-women (MSW) and MSM) and pharyngeal and rectal swabs (MSM). Routine clinic results were obtained and FTD Urethritis Plus kit used to detect MG. Risk factors (RFs) were analysed using univariate (UV) and multivariate (MV) logistic regression.

Results

Abstract P206 Table 1 Prevelance and risk factors associated with STIs

	Females n=305	MSW n=174	MSM		
			Urine n=79	Rectal n=80	Pharynx n=87
CT % (95% CI)	8.20 (5.61–11.82)	20.96 (15.43–27.47)	6.33 (2.73–13.97)	7.50 (3.48–15.40)	1.18 (0.21–26.80)
MG % (95% CI)	7.54 (5.08–11.06)	17.82 (12.84-24.18)	1.27 (0.22–6.83)	8.75 (4.30–16.98)	0.00 (0.00–4.23)
NG % (95% CI)	1.31 (0.51–3.32)	6.32 (3.57-10.96)	13.92 (7.96–23.24)	27.50 (18.92–38.14)	17.44 (10.86–26.80)

The only RFs associated with any organism in MV analyses was in females. Being aged 16–19, a contact of someone with an STI, and not bleeding were associated with CT and being a contact was the only RF for NG.

Discussion CT and MG positivity were highest in MSW compared with other patient groups, whereas NG positivity was highest in MSM, especially rectal samples. In the absence of routine MG testing, NG-positive MSM would be treated with 1 g azithromycin, (combined with 500 mg ceftriaxone) which could result in MG antimicrobial resistance development. From our study population, with no RFs for CT, NG or MG, a targeted test and treat approach would not be beneficial in MSW or MSM.

P207 OUTBREAK OF HEP A AFFECTING MSM: THE LONDON RESPONSE

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Introduction: Outbreaks of hepatitis A virus (HAV) have previously been described in men who have sex with men (MSM). BASHH only recommends HAV vaccination for MSM during outbreaks. A UK cluster of HAV cases was identified and, by 27/2/2017, London had 45 probable and confirmed cases in MSM. London sexual health commissioning is in flux with new arrangements imminent.

Methods: For individual notified cases, Health Protection Teams (HPT) routinely assess source, offer infection control advice to the case and organise vaccination of household and sexual contacts. A London outbreak control team (OCT) comprised epidemiologists, commissioners and providers of immunisation and sexual health services, health promotion partners and communications. The OCT scoped possible additional interventions to control the outbreak.

Results:

The OCT recommended: Awareness raising re risk behaviour: Distribute a nationally commissioned leaflet with safer sex advice to cases and to genitourinary medicine (GUM) clinics, plus relevant content on digital platforms.

Liaison with providers, commissioners: Inform GPs. Survey current practice in GUM for HAV immunisation. Vaccinate MSM opportunistically in GUM clinics (if had a new or casual partner in last 3 months).

Link with existing health promotion networks: Working with gay venues, to get understanding and cooperation.

Set up vaccination clinics near the popular venues

Discussion: It is challenging to set up an immunisation programme in a large city with complex commissioning relationships at short notice. Consideration should be given to vaccination between outbreaks to reduce the proportion susceptible, or 'outbreak ready' plans included in sexual health commissioning arrangements.

P208 IN AN ERA OF ANTIBMICROBIAL STEWARDSHIP IS EPIDEMIOLOGICAL TREATMENT FOR SYPHILIS STILL JUSTIFIED?

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Introduction The BASHH guidelines for syphilis recommend the offer of epidemiological treatment or re-screening at 12 weeks (12w) after exposure for asymptomatic sexual contacts. We reviewed local practice and compliance with guidance in view of the increasing need for antimicrobial stewardship.

Methods We conducted a retrospective case note review of patients coded as syphilis contact (PNS) between January 2015 and July 2016.

Results We identified 44 patients (40 [91%] male; 35 [80%] men who have sex with men) reporting syphilis contact. There were 12 (27%) symptomatic, who were all given treatment; 7