

Results Isolates were recovered from: urethra (36), endocervix (3) and conjunctiva (1). Results of MIC 50 and MIC 90 ($\mu\text{g/ml}$) were: PEN 0.5 and 4; TET: 1 and 32; CIP: 1 and 4; AZI: 0.25 and 0.5; CFX: 0.016 and 0.03; CRO: 0.008 and 0.016. Isolates with combined resistance to CIP-AZI-PEN, PEN-TET-CIP and CIP-TET-AZI were observed. Cephalosporin resistant Ng isolates was not observed although 2 isolates with decreased susceptibility to CFX (MIC 0.125 $\mu\text{g/ml}$) were found. The patient medical records were reviewed and no epidemiological relation was found among the patients with harbour strains with simultaneous resistance and clinical features. Patients were treated with CRO 500 mg IM plus AZI 1 g. The post treatment clinical controls were negative.

Conclusion The finding of Ng strains with decreased susceptibility to third generation cephalosporins is a warning signal. In addition to this, the presence of isolates with resistance to different classes of antibiotics, support the need to strength surveillance studies, evaluate treatment failures and improve prevention strategies to control of gonorrhoea in our population.

P3.224 PARTNER NOTIFICATION AND PARTNER TREATMENT FOR CHLAMYDIA: ATTITUDE AND PRACTICE OF GENERAL PRACTITIONERS IN THE NETHERLANDS

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Introduction: *Chlamydia* prevalence remains high despite scaled-up control efforts. In the Netherlands, the majority of chlamydia patients are seen by general practitioners (GPs). Partner notification (PN) and partner treatment (PT) are addressed in GP guidelines but may not be fully covered in daily practice. As part of a larger research project into the potential of direct partner treatment for chlamydia (PICC-UP: Patient Initiated Contact treatment for Chlamydia), we investigated current practice and attitude of GPs towards PN/PT.

Methods Multiple data-sources were combined. First, we collected information on current practice via two short questionnaires around a national GP conference: a pre-conference survey (n=1411) and a handout one on location (n=271). Furthermore, quantitative data on (potential) PT were obtained from prescriptions in electronic patient data from 311 practices in the NIVEL Primary Care Database and from additional data on STI consultations in a subgroup of 45 sentinel practices. Finally, we obtained more insight into GPs' attitude towards PN/PT in a vignette study among GPs in the same network (n=268).

Results In the questionnaires, the large majority of GPs (>95%) indicated to discuss PN of current and ex-partner(s) with chlamydia patients. Usually, GPs leave further steps to the patients (83%); partners are rarely treated directly (4%), except when partners are registered in the same practice (16%). Of all prescriptions of Azithromycin linked to chlamydia episodes, 2% were double dosages, presumably for PT. At

STI consultations, the partners of 6/100 chlamydia patients were treated directly, either via partner prescription or double doses for the index patient. Test-results were communicated over the telephone in two thirds of chlamydia diagnoses, limiting the options for PN/PT. In the vignette study, the GPs' attitude appeared to be more open to PT than in current practice: 16%–20% of GPs indicated willingness to provide direct PT, depending on patient/partner profile; a larger group (24%–45%) would prescribe treatment for an (unseen) partner if the patient could notify him/her first. Advantages of direct PT given by the GPs were: better transmission control because of a higher chance to treat partners (at the same time), easier, cheaper. Disadvantages mentioned were: no chance to talk and give advice to partners, over-treatment, leading to resistance, impact on patient-GP relation and privacy. GPs were concerned about prescribing antibiotics for a patient they have not seen. The opinion of 10% of GPs was that direct PT should be possible for partners of all chlamydia patients, 21% thought for many, others only for some or by exception, while 11% was not in favour of it at all.

Conclusion At present, GPs in the Netherlands rarely treat partners of chlamydia cases directly, except for partners registered in the same practice. GPs may be open to options for direct PT, provided there are clear guidelines to arrange this legally and practically.

P3.225 NEISSERIA GONORRHOEAE BACTERIAL LOAD DIFFERS BETWEEN SAMPLE SITES

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Introduction To date, there is limited data on *Neisseria gonorrhoeae* (NG) bacterial load in relation to transmission and symptoms of NG infection. Also, extra-genital sites are not often tested apart from specific risk groups. This could lead to untreated infections that potentially facilitate transmission of NG. In this study we describe the NG bacterial load in relation to sample site, sexual orientation, and age.

Methods Routine diagnostics samples of the STI clinic of the South Limburg Public Health Service between 2012 and May 2016 were used. In this period, 1141 samples (883 male and 258 female) from 836 patients were NG positive, among which 237 urine samples, 130 genital swabs, 394 anorectal swabs, and 380 oropharyngeal swabs. Bacterial load was determined by interpolation of a standard curve using the COBAS 4800. Multiple linear regression was used to describe bacterial load in which sample site, sexual orientation, and age were the determinants.

Results In 471 of 629 (74.9%) patients with an extra-genital NG positive sample, only the extra-genital sample was positive, among these were 367 men who have sex (MSM) with men, 34 heterosexual men (HSM), and 70 women. Most patients were positive at a single sample site, 221 oropharyngeal (130 MSM, 32 HSM, and 59 women) and 165 anorectal respectively (154 MSM, 2 HSM, and 9 women). Sample site and age were significant determinants for load (both $p < 0.001$), in contrast to sexual orientation ($p = 0.096$). When