rectal chlamydia infections. The pharmacokinetic properties of azithromycin may also contribute to the development of macrolide resistance in other STIs including gonorrhoea and *Mycoplasma genitalium*. It has extensive tissue distribution with the majority of the drug confined to the intracellular space. After entering the acidic compartments of cells, it becomes trapped leading to its slow release from the tissues contributing to its long half-life. While this is effective for treating chlamydia, the long half-life results in sub-inhibitory levels in the extracellular space, potentially contributing to the development of macrolide resistance in other organisms. This is particularly an issue when new infections are acquired during the two weeks following azithromycin treatment when sub inhibitory concentrations exist. This presentation will discuss how the pharmacokinetic properties of azithromycin affect its efficacy for treating chlamydia infections and whether it should have an ongoing role as part of a dual treatment regimen with ceftriaxone for gonorrhoea infections.

Disclosure No significant relationships.

S13.2 SHOULD ENTERIC INFECTIONS IN MSM ALWAYS BE TREATED?

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10.1136/sextrans-2019-sti.62

Sexual transmitted enteric infections (STeIs) have been well recognised in gay, bisexual and other men who have sex with men (GBMSM) for over three decades. This presentation will initially provide an overview of the range of enteric pathogens with propensity for sexual transmission in this population.

There has been a recent increase in the numbers of outbreaks of enteric infections reported affecting this population in particular with shigella species and Hepatitis A. These have occurred across borders reflecting internationally mobile GBMSM networks. Recently, multi-drug antimicrobial resistance (AMR) in strains of *Shigella sonnei* circulating amongst GBMSM in England and USA have been identified challenging standard treatment approaches. The epidemiology of some of these outbreaks, the emergence of AMR and public health responses will be discussed. Outbreaks of shigella have been linked to HIV status and parallel epidemics of gonorrhoea (also linked with AMR), syphilis and Lymphogranuloma venereum in this population of GBMSM.

Whilst the majority of shigella infections in GBMSM will be self-limiting, contextual and clinical factors may lower the threshold for antimicrobial treatment. The presentation highlights some of these challenges and dilemmas in clinical management particularly in the face of co-infection with STIs, the emergence of AMR and syndemic health inequalities such as problematic chemsex (use of psychoactive substances with sex).

The presentation will conclude with research gaps, implications for policy on STeIs and emphasize the need for partnership working across public health, microbiology and relevant frontline clinical services. The need for management approaches that are holistic and consider wider syndemic health needs when managing patients will also be highlighted.

Disclosure No significant relationships.

S13.3 DO RECTAL BACTERIAL STIS IN WOMEN MATTER? WHO SHOULD WE TEST AND WHEN?

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Rectal bacterial STIs are increasingly recognized as common infections among clinic-attending women, with estimated prevalences of 5% for rectal *Neisseria gonorrhoeae* (GC) and 9% for rectal *Chlamydia trachomatis* (CT). Although these prevalences are similar to urogenital GC and CT among these same populations of women, we know very little about the health implications or epidemiology of rectal STIs among women. Rectal STIs are typically asymptomatic and the infections themselves may not be morbid conditions. However, some investigators have hypothesized that women could autoinoculate bacteria from the rectum to the vagina which may result in reproductive tract sequelae in the absence of vaginal sex. Even if there were strong evidence to suggest this does occur, it is unclear which populations of women should be targeted for rectal screening. Employing current screening guidelines for urogenital infections would assure treatment of women with concurrent rectal STI, but would miss women with isolated rectal STI. Further, the efficacy of azithromycin for CT may be lower in the rectum than the urogenital tract, suggesting that screening and treating women for urogenital CT without regard to the presence of rectal CT may result in a persistent rectal infection. Alternatively, rectal STI screening could be limited to women who report anal sex. However, the prevalence of rectal STIs is similar among women who do and do not report anal sex, suggesting that this screening strategy would miss a substantial proportion of cases. Finally, some have hypothesized that oral acquisition of CT may lead to rectal infection. If this route is possible, rectal screening for women who report penile-oral sex may be warranted. This session will review the epidemiologic and microbiologic evidence on these topics and will discuss what studies are needed to address the gaps in our understanding of these infections and define a way forward.

Disclosure No significant relationships.

S13.4 HPV VACCINATION IN MSM: WHO SHOULD BE VACCINATED AND IS THERE A ROLE FOR VACCINATION OF OLDER AND/OR HIV-POSITIVE MSM IN PREVENTING INITIAL, PERSISTENT AND RECURRENT HPV AND RELATED DISEASES?

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Background Anogenital infection with human papillomavirus (HPV) disproportionately affects men who have sex with men (MSM), especially those living with HIV. It remains unclear whether HPV vaccination of older MSM and/or MSM living with HIV is beneficial in terms of preventing new HPV infections, reinfections with the same HPV subtype, new diagnoses or recurrence of HPV-related lesions or anal cancer.

Results HPV16 causes most anal squamous cell cancer worldwide. However, other high-risk HPV (hrHPV) types contained in the 9-valent vaccine (9vHPVvax) cause a substantial minority of anal cancers in HIV-positive MSM. In the landmark