(3%) had a NRTI mutation, six (3%) had at least one nNRTI mutation and 4(2%) had a PI mutation. There were no dual/triple class/INI mutations. There was no significant change in the prevalence of TDR over the study period. The overall prevalence of non-B subtype was 53/212(25%;95% CI=19.6–31.2), and was not more frequently seen in non-UK born individuals (OR=1.24;CI=0.66–2.33,p=0.51). Patients with TDR were older [45.v.36 years, p=0.006] and have non-B subtype (OR=2.96;CI=1.08–8.13,p=0.03). Although overall rates of bacterial STIs was high (34%), having a bacterial STI was not associated with TDR (OR=1.77;95%CI=0.66–4.82,p=0.26).

Conclusion TDR is associated with age and non-B subtype in our population. HIV TDR is not decreasing locally and remains a small but significant concern despite effective HIV prevention strategies, which may not reach hidden populations affected by HIV. Continued efforts to reduce HIV transmission must target hidden populations and we must maintain adequate surveillance of TDR.

P026 SEXUALLY TRANSMITTED SHIGELLA FLEXNERI AND SHIGELLA SONNEI IN MEN WHO HAVE SEX WITH MEN

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Shigella outbreaks in MSM are associated with sexual networks involving transmission of other sexually transmitted infections (STIs), geosocial app use for meeting sexual partners and chemsex. There is increasing antimicrobial resistance (AMR) in Shigella amongst MSM. We aimed to describe cases and patterns of AMR amongst MSM with Shigella between 2016–2019.

There were 33 cases of shigellosis in MSM identified, with a median age of 38-years (IQR 34–47). 11/33(33%) reported recent chemsex use, 14/33(42%) were HIV positive. Of the 19/33 HIV negative MSM, 7/19(37%) were using HIV pre-exposure prophylaxis. The mean number of sexual partners in the previous 3 months was six. 15/33(45%) had Shigella sonnei, 5/33(15%) Shigella flexneri, and 13/33(39%) were DNA-PCR positive but culture negative. 14/33(42%) were diagnosed with at least one other STI. MSM with Shigella flexneri were more likely to be HIV positive than Shigella sonnei(p<0.05). Antimicrobial sensitivities were only available in 11/15 cases of Shigella sonnei[fully sensitive(9%), resistant to ciprofloxacin (9%), resistant to azithromycin(36%), resistant to ciprofloxacin and azithromycin(45%)]. 7/33(21%) were treated presumptively on the day of presentation with intramuscular ceftriaxone 2g for 1–3 days followed by oral ciprofloxacin. No MSM with ciprofloxacin resistance received ciprofloxacin; the remaining 26/33 (78%) did not receive antimicrobials and their diarrhoea resolved.

We have shown that Shigella flexneri is more frequently seen in HIV positive MSM and is associated with chemsex, and resistance to both azithromycin and ciprofloxacin is common in Shigella sonnei. The increasing use of PCR culture independent diagnostic tests make it more difficult to identify cases and clusters within sexual networks in MSM of multi-drug resistant shigellosis: clinicians and microbiologists should be vigilant when managing MSM with diarrhoea to prevent large outbreaks of highly resistant shigellosis.

P027 HOW WOULD SEXUAL HEALTH CLINICIANS MANAGE FIRST ATTENDANCE OF MEN WHO HAVE SEX WITH MEN WITH ANO-GENITAL ULCERS?

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Background There has been a significant increase in infectious syphilis in men who have sex with men(MSM). Primary syphilis classically presents as painless ano-genital ulceration however recent data suggests that up to 50% of lesions are painful. We aimed to discover current clinical practice when experienced sexual health clinicians are faced with MSM presenting with ano-genital ulcers.

Method An anonymous online survey was sent to clinicians in Brighton, UK and Western Sydney, Australia.

Results Twenty-nine sexual health clinicians (17 doctors and 12 nurses) from the UK (Brighton) and Australia (Sydney) responded to an anonymous online survey; (16/29,55%) had been working in sexual health for more than ten years. In the absence of dark-field microscopy, when faced with a scenario of a non-penicillin allergic MSM with a 5-day history of a large painless penile ulcer, 26/29(90%;95%CI=78.6–100.7) would treat presumptively on the day. Most(21/29, 72%;95% CI=56.1–88.7) would treat MSM presumptively for syphilis with a large painful anal ulcer. Sexual health clinicians are more likely to offer empirical treatment based upon (1) clinical history (number of sexual partners, previous syphilis, sexual contacts of syphilis, PrEP use, HIV positivity, chem-sex), (2) clinical examination (confidence with clinical diagnosis or having ‘classical features’ of syphilis) or (3) patient factors (vulnerability factors, less likely to return for treatment or abstain from sex), and are less likely to offer presumptive treatment if they have penicillin allergy, a painful lesion and acceptable laboratory reporting times.

Conclusion In the absence same day highly sensitive assays, experienced sexual health clinicians are managing MSM with ano-genital ulcers based upon sexual history, clinical examination and patient factors. The turn-around-times for laboratory-based assays are vital for syphilis control and prevention. To reduce infectious syphilis, we need to improve access to real time, ideally point-of-care, molecular assays for detection of Treponema pallidum in ano-genital ulcer samples.

P028 SYMPTOMATIC LYMPHOGANULOMA VENEREUM (LGV) PROCTITIS IN MEN WHO HAVE SEX WITH MEN (MSM)

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Lymphogranuloma venereum (LGV) is a sub-type of Chlamydia trachomatis and is associated with proctitis. LGV proctitis is associated with recreational drug use particularly chemsex, HIV, hepatitis C, and other sexually transmitted infection transmission. The presenting symptoms of LGV proctitis are not well characterised. We aimed to describe the rectal

symptoms of HIV positive and HIV negative MSM with LGV proctitis.

This is a cross-sectional study of MSM who tested positive for LGV attending our large STI centre in Brighton, UK between January 2013 and December 2019. We collected data on age, number of recent sexual partners, ano-rectal symptoms, HIV status, use of HIV Pre-exposure prophylaxis (PrEP) and recreational drug use.

49 MSM had a positive rectal LGV PCR between 2013–2019. The median age was 45 years (IQR=39–53), 44(90%) of the MSM tested were symptomatic and the remaining five were asymptomatic. Eleven (22%) reported recent chemsex, 35(71%) were HIV seropositive and six(43%) of the 15 HIV negative MSM were using PrEP. The symptoms described by the symptomatic MSM were: rectal pain[27,(61%)], rectal bleeding[21,(54%)], rectal discharge[23,(52%)], diarrhoea[8,(18%)], tenesmus[6,(15%)] and constipation[5,(13%)]. There were no significant differences between the characteristics and presenting symptoms between HIV positive and negative MSM.

The symptoms of MSM diagnosed with LGV proctitis are varied and there were no differences between HIV positive and negative MSM. The heterogeneity of presenting symptoms of MSM with LGV proctitis leads to missed opportunities for diagnosis, increased morbidity due to delays in diagnosis and implications for onward transmission particularly where clinicians are not so familiar with LGV or do not have access to testing. Increasing awareness of the heterogeneity of the presentation of LGV in MSM may improve the diagnosis and the impact of public health campaigns to control LGV.

P029 PHARYNGEAL CHLAMYDIA TRACHOMATIS IN HIV POSITIVE AND HIV NEGATIVE MEN WHO HAVE SEX WITH MEN (MSM)

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Background Simultaneous testing for both Gonorrhoea and Chlamydia using dual nucleic acid amplification tests (NAAT) has increased pharyngeal Chlamydia testing in MSM. There has been increasing interest in pharyngeal Gonorrhoea due to emerging Gonorrhoea antimicrobial resistance but less is understood about the characteristics of pharyngeal Chlamydia in MSM.

Methods We aimed to explore the prevalence and associated features of pharyngeal Chlamydia amongst HIV positive and negative MSM in a large urban population. We collected data on HIV status, pharyngeal symptoms, number of recent sexual partners, use of HIV pre-exposure prophylaxis (PrEP), concomitant STIs, previous history of syphilis and current smoking status. Statistical analysis was performed using bivariate odds ratio and Mann Whitney U tests and 95% confidence intervals.

Results In 2019, 6613 MSM attended for pharyngeal STI testing. 75/6613(1.13%,95%CI=0.9–1.14) tested positive for pharyngeal Chlamydia. The median age was 35 years (IQR=28–43), the median number of sexual partners in the preceding 3 months was three, four(5%) reported throat symptoms, 22(29%) were current smokers, 20(26%) were HIV

positive, and 24(44%) of the HIV negative MSM were using PrEP. MSM with pharyngeal Chlamydia often had multi-site infection; rectal chlamydia[39(52%)], urethral chlamydia[12(16%)], and concomitant infection; early syphilis[2(3%)] and gonorrhoea at any site[14(19%)]. Twenty two(29%) had previously treated syphilis. HIV positive MSM with pharyngeal Chlamydia were significantly more likely to have had previous syphilis(OR=4.9,95%CI1.6–14.7,p=0.005) and were significantly older(p=0.02) than HIV negative MSM.

Conclusion We have shown that the prevalence of pharyngeal Chlamydia is 1.13% in MSM and only 5% reported pharyngeal symptoms, similar to other studies. HIV positive MSM with pharyngeal Chlamydia were older and more likely to have had previous syphilis. Further research is needed to explore the characteristics of pharyngeal Chlamydia and the benefits of increased screening for asymptomatic pharyngeal Chlamydia in MSM.

P030 HIV POST-EXPOSURE PROPHYLAXIS TO PRE-EXPOSURE PROPHYLAXIS TRANSITIONING IN MEN WHO HAVE SEX WITH MEN

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Background HIV post-exposure prophylaxis following sexual exposure (PEPSE) and pre-exposure prophylaxis (PrEP) are used by people at sexual risk of HIV acquisition including men who have sex with men (MSM). Owing to the high risk of HIV seroconversion due to on-going risk behaviours, it is becoming commonplace for HIV-negative MSM requiring PEPSE (e.g. HIV sexual-exposure within 72-hours) to transition immediately to PrEP following the 28-days of PEPSE. We aimed to review how frequently PrEP is discussed and used by MSM following PEPSE.

Method We reviewed the electronic notes of MSM who had accessed PEPSE between January 2018 – November 2020 and collected information on sexual assault, recreational drug use at the time of PEPSE initiation, whether direct transition to PrEP had been discussed, and if PrEP had been initiated after PEPSE.

Results During the study period, 277 MSM accessed PEPSE. The median age was 32 years (IQR 26–43), 17 (6%) started PEPSE following a sexual assault, 36 (13%) were using recreational drugs during sex and 30(11%) had used PrEP previously. Discussion about direct transition to PrEP after PEPSE was documented in 155 (56%) MSM, including 128 (51%) MSM who had never used PrEP before, and 67 (24%) MSM actually transitioned directly from PEPSE to PrEP. Clinicians were more likely to discuss PEPSE to PrEP transition in MSM with prior PrEP use (p<0.0001), and MSM were more likely to transition to PrEP from PEPSE if they had used PrEP previously (p<0.00001).

Conclusion Only 56% of MSM who used PEPSE had a documented discussion about transitioning to PrEP and only a 24% actually transitioned from PEPSE to PrEP. Where indicated, MSM who access PEPSE should have a documented discussion and ideally transition immediately onto PrEP following completion of PEPSE.