P13 NEW HIV DIAGNOSES IN A BUSY INNER-CITY COHORT: HOW FAR HAVE WE COME?

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Background Our service is located in a high HIV prevalence area (6.2/1000), and a large proportion of late presentations. We have widened the availability of HIV testing as a major strategy to reduce HIV related morbidity and mortality in our population.
Aims/Objectives To assess the evolving trends in demographics, clinical and laboratory findings of newly diagnosed HIV patients in our busy inner city clinic. To develop HIV testing strategies further with the implementation of current NICE guidance that recommends testing all medical admissions, and assess the potential future impact of this on presentation patterns in our cohort.
Methods Retrospective case note review of 92 consecutive new HIV diagnoses between 2009 and 2011. Data were collected on demographics, clinical stage, CD4 count, source of referrals, and drug resistance. Findings were compared to previous data sets in the same clinic over three audit periods between 2003 and 2011.
Results The proportion of males newly diagnosed has increased from 33% (2003) to 51% (2011), and the median age of all diagnoses has crept up to 39.5 years from 36.7 years. The proportion of referrals from primary care is now the largest (51%). Very late presenters (CD4 <200), remain high in our population at 53%, and this is well above the national average of 30%. Primary drug resistance is 16%, currently double the national average.
Discussion/Conclusions There continues to be a high rate of very late presenters in our cohort. Strengthening current interventions and implementation of NICE guidance will be essential in an effort to reduce late diagnoses.

P14 PATHWAYS TO HIV DIAGNOSIS AND TREATMENT AMONG MIGRANTS AND THEIR PARTNERS IN INDIA

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Background An estimated 2.3 million people are living with HIV in India. Although free testing and treatment is available, <20% of HIV-positive people access treatment at its antiretroviral treatment (ART) centres. Short-term labour migrants have been identified as at risk of acquiring and transmitting HIV.
Aim To explore the pathways to HIV testing and treatment for people with a history of short-term circular migration, and their partners.
Methods A qualitative study at an ART centre in northern India, using in-depth interviews. Data were analysed using framework and thematic content analysis.
Results 34 people were interviewed, 20 men and 14 women. Men commonly reported becoming unwell while working away from home and enduring a prolonged period of sickness during which they received various temporary symptomatic treatments from private medical providers. Their HIV was only diagnosed and treatment started when their illness overwhelmed them and they returned home as a consequence of a medical or financial emergency. In contrast, female participants were more likely to be tested following a positive diagnosis of their husband. Individuals who were now on ART felt insecure about migrating again given the instability of the migrant labour market and fears about ability to adhere to treatment at destination.
Discussion Diagnosing and treating HIV infection early is an important way to slow down the spread of the epidemic and targeting those at greatest risk should be a priority. However, despite migrant-focussed awareness campaigns, migrant workers and their partners are not accessing testing and treatment until they become sick. The cultural preference for private treatment, the insecurity of migrant work and gender differences in health-seeking behaviour delay early diagnosis and treatment initiation.

P15 ARE WE FOLLOWING BHIVA GUIDELINES IN NEWLY DIAGNOSED HIV PATIENTS?

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Background BHIVA published guidelines in 2008 on the treatment of HIV infected adults. These guidelines were used as a basis for optimal patient care.
Aims To audit the following against BHIVA guidelines: (1) Initial investigations, assessment and monitoring after diagnosis (2) Choice of first line ARV regimen (3) Attainment of target HIV viral load <50 by 6 months of treatment (4) G.P. involvement in patient care.
Methods The medical records of 24 HIV positive patients, who were diagnosed and started on ARV medication during the preceding 12 months, were reviewed.
Results Initial investigations and assessment were done in all patients (100%), with the exception of cardiovascular risk assessment which was documented in only 20% of patients. 18/24 patients (75%) were started on the first line regimen recommended [2NRTI and 1 NNRTI], out of which 14 patients (58.3%) were started on Atripla. 5 patients (20.8%) received [2NRTI and boosted PI] and one patient was on [2NRTI and integrase inhibitor]. 20 patients (83.3%) achieved the target VL<50 within 6 months of treatment. In 3/24 (12.5%) patients the viral load was still detectable at 6 months. One patient moved away from the region. The G.P. was informed about the HIV positive status in only 62.5% patients.
Conclusion Several areas of clinical practice were identified for improvement and the following actions recommended: the use of a web-based virtual clinic resource which includes links to CVS risk calculators; proactive discussion with patients regarding the importance of disclosure of HIV status to their GP for safe and efficient care.

P16 WHAT WERE THE REASONS FOR LOW CD4 COUNTS IN PATIENTS STARTING ANTIRETROVIRAL (ARV) MEDICATION?

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Background Our ARV Network's 2009 audit highlighted the large proportion of patients with a CD4 count <350. A re-audit was designed to provide more information on patients with CD4 counts in this range.
Methods We conducted a retrospective review of case notes for all patients in the network starting ARVs in 2010. For analysis of CD4 counts the cohort was divided into two groups; those diagnosed within 1 year of starting treatment and others.
Results 114 patients started ARVs in 2010 from four centres in our network. 62 (54.4%) were male. Mean age was 38.4 years (range

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