Improving Clinical Practice and Service Delivery

P097 ABSTRACT WITHDRAWN

P098 EVALUATION OF THE PERFORMANCE OF HCV AG IN ROUTINE SCREENING FOR HEPATITIS C IN HIGH-RISK POPULATIONS

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Introduction Screening high-risk populations for hepatitis C (HCV) using antibody (anti-HCV) does not immediately distinguish resolved and active infections and may miss acute infections. HCV core-antigen (HCVAg) screening has been introduced in laboratories supporting some UK sexual health clinics. We evaluated Abbott Architect's automated HCVAg immunoassay for HCV screening.

Methods Testing was introduced in May 2015 for those reporting HCV risk in the past 6 months, and annual screening for all HIV-positive individuals. HCVAg-positive samples were tested in duplicate, then tested for HCV–RNA. Few samples were tested for both HCVAg and HCV-RNA in the initial few months. Results for all tests performed May 2015–April 2016 were reviewed.

Results 5132 samples were tested for HCVAg. 113/5132(2%) were HCVAg positive. 139 samples had both HCVAg and HCV-RNA tested. Using HCV-RNA as the gold standard, HCVAg sensitivity was 99%; positive predictive value 63%. Specificity was 39%; negative predictive value 96%.

Abstract P098 Table 1 Evaluation of HCV Ag test

	HCV-RNA detected	HCV-RNA not detected
HCVAg+ve	71	41**
HCVAg-ve	1*	26

The HCVAg negative/HCV-RNA positive individual had low viral load (130c/ml).

Of the 41 HCVAg positive/HCV-RNA negative individuals; 30(73%) were retested later and were HCVAg negative and HCV-RNA or anti-HCV negative. 3(7%) were persistently HCVAg positive but HCV-RNA negative; 7 had no follow up samples; 1 subsequently became HCV-RNA positive.

Discussion The specificity of HCVAg in our cohort is lower than that published in a recent systematic review (93% sensitivity/99% specificity). False positive results cause distress for patients and additional laboratory costs, however the increased sensitivity for acute infection may lead to earlier diagnosis in high-risk populations.

P099 TV OR NOT TV: USING NAATS TO IMPROVE THE COST EFFECTIVENESS OF TESTING

Audit of the management of patients with trichomonas vaginalis, using nucleic acid amplification technique (naat) testing in a high tv prevalence area

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Introduction In April 2016, we changed from TV culture to BD Viper NAATs testing and from testing all women to only testing women who were symptomatic, STI contacts, had previous TV and male contacts of TV.

Methods Laboratory data and SHHAPT codes retrospectively identified all patients diagnosed with TV between 1 May – 30 November 2016. Electronic patient records (EPR) were reviewed and data analysed in Excel.

Results There were 96 new diagnoses, 93 females and 3 males, median age 31 (IQR 24–40). 66% Black Afro-Caribbean; 3 were sex workers. 91% symptomatic, 22% had STI co-infection, 26% bacterial vaginosis, 7% candida and 32% previous TV.

Wet prep microscopy (WPM) detected 65% of symptomatic cases. Treatments were Metronidazole or Tinidazole.

The audit standards our service achieved (BASHH performance standards target- 97%) were: 100% received appropriate antibiotics, 51% written information receipt documented, 90% had partner notification recommended (PN) and 28% PN confirmation.

Abstract P099 Table 1 Cost analysis summary

	2015 (Culture)	2016 (NAATs)
Tested	3054	1859
Positive	84	117
New infections	73	96
Cost	£19,851	£15,486

Discussion TV NAATs cost more than culture but changing our protocol reduced the overall cost while increasing the number of new diagnoses; enabling us to target testing to patients at highest risk. 35% (27) were missed on WPM. 9.3% (9) were asymptomatic and detected because of testing as contacts of TV/sex worker/cervical cytology detection. Recommendations include: staff training to improve completion of PN and modifying our EPR fields to improve documentation of leaflets having been given.

P100 PRIME: A WEB-BASED HIV RISK REDUCTION PACKAGE FOR HIGH-RISK MSM

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