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

17–62). Ethnicity data showed only 37.7% were white with the majority being Black (54.4%). 6 (7.0%) of 85 patients had a major NNRTI resistance mutation. Mean nadir CD4 count was 222 (range 5–610). 101 (88.6%) patients had a CD4 count under 350. 106 reasons for low CD4 count were recorded. 65 patients (64.3%) had low CD4 counts because of late diagnosis, 15 (14.8%) had declined ARV when initially offered while 10 (9.9%) had been lost to follow-up. The patients starting Rx within 1 year of diagnosis (no=67) had a lower mean nadir CD4 count compared to those diagnosed earlier (no=47) (162 cells vs 271 cells, p<0.5). There was no difference between the two groups in the number of patients having a pre-treatment resistance test, the mean CD4 rise 6 months after treatment initiation and the proportion of patients having an undetectable viral load 12 months after treatment initiation. At 6 months the mean CD4 count had risen from 222 at treatment initiation to 360, but 54 (47.4%) still had a CD4 count under 350. The main reasons for this were poor immune recovery in 80.7%, poor adherence 7%, poor attendance 5.3%.

Discussion A proportion of our cohort started ARVs with a low CD4 count mainly due to late diagnosis. This is an important barrier to ARV initiation and needs to be addressed and our audit data would support the need for extra support and resources directed to earlier HIV diagnosis.

P17 FOUR YEARS OF POST EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE (PEPSE) PRESCRIBING AFTER SEXUAL ASSAULT IN A SEXUAL ASSAULT REFERRAL CENTRE (SARC)

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Aim We have reviewed 4 years of PEPSE use in our SARC and its follow-up and compared with BASHH guidance on PEPSE after sexual assault.

Methods Retrospective review of SARC and GUM notes from 12 October 2007 to 12 October 2011

Results 1233 cases seen 127 given PEPSE, for two notes not available Age range 14–55 years mean 27. 81% were female. 51% were vulnerable. Ethnicity of assailants, 81 White European, 20 African, 5 Asian, 4 Dark European, 13 unknown. One man had PEPSE twice. Mean time till received PEPSE was 25 h range 3–168 h, 5 over 72 h. Using BASHH guidelines PEPSE was *recommended* in 22%, *considered* in 50% and 26% was *not recommended* as either >72 h or low risk exposures. 87 returned at day 3 for review. 29 stopped PEPSE early. One was HIV positive at baseline, 12 due to side-effects, three felt the assault was low risk of HIV at review, 13 for other reasons. 27% returned for HIV test at 3 months, 14% at 6 months. No seroconversions seen. 17% completed PEPSE. 43 given PEPSE while on interacting drugs. Eight were identified and given appropriate management. Most common interaction was hormonal contraception.

Discussion Completion rates for PEPSE were low and similar low rates have been seen in alike studies. No long-term side effects were seen but only 19% of interactions were identified. PEPSE is a risk reduction method and so clients should not be put at risk of serious drug interactions. 33 were given PEPSE for low risk exposures which is "not recommended" by BASHH. 10 of these accepted full PEPSE course. The decision to start PEPSE is often made under stressful conditions so GUM now review need for PEPSE after completing the starter pack. It is vital staff starting PEPSE prescribe within the guidelines and they and GUM staff consider interactions. We have created a proforma which reminds staff only to give within 72 h and review interactions. It also outlines HIV risks after exposure and hopefully make it easier to discuss this with the client.

P18 POST EXPOSURE PROPHYLAXIS FOLLOWING POSSIBLE EXPOSURE TO HIV INFECTION: AN EVALUATION OF 391 ATTENDANCES AT THREE CENTRAL LONDON SEXUAL HEALTH CLINICS

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Background Providing post exposure prophylaxis (PEP) following possible HIV exposure is a common GU presentation. However, few studies have evaluated this practice.

Aim(s)/Objective(s) To answer the following on PEP presentations: age, sex, nature of exposure to HIV, time to presentation for PEP, side effects, completion rates, presence of sexually transmitted infections (STIs), appropriateness of PEP dispensing and comparisons of findings with other published studies.

Methods GUM clinic attendances were evaluated from April 2009 to March 2010.

Results There were 391 PEP attendances: 373 males (96% MSM), 18 females. Age range 19–57 (mean 35.4) years. Presentation followed anal sex in 89%, vaginal sex in 5%. The remainder attended following oral sex, splash incidents, injecting drug use, or other exposure. Forty six percent attended within 24 h, in one instance PEP was dispensed beyond 72 h. The majority completed PEP (82%). GI side effects were experienced by 60%. Baseline screening for hepatitis B showed active infection in 1% and immunity in 74%. A baseline HIV test was conducted in all but one patient. An STI screen was conducted at or around day 14 in 69% of patients, with 12% testing positive for an STI in line with previously published data. Follow-up rate at 3–6 months was 52%: Of 203 patients tested for HIV at follow-up, 2 (1%) tested positive.

Conclusions PEP was dispensed appropriately in the majority of cases. The fact that 82% of individuals completed treatment despite side effects is likely to be due to the use of more tolerable regimens than were used historically. The presence of an STI in 12% of people tested highlights the importance of screening in individuals presenting for PEP. The fact that only 52% of patients attended for a follow-up HIV test at 3–6 months is of concern and warrants further exploration.

P19 WHAT'S UP? ERECTILE DYSFUNCTION (ED) IN HIV POSITIVE MEN

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Background Antiretroviral therapy in HIV positive patients has resulted in improvements in survival, quality of life and fulfilling sexual relationships. Treatment using phosphodiesterase type 5 inhibitors (PDE5i) for ED has simplified management. However nitrates, including "poppers", and protease inhibitors (PIs) can interact with PDE5i leading to hypotension and high levels of PDE5i. Ethical issues are a consideration as treatments can lead to HIV transmission if safer sex is not practised. We reviewed our HIV positive men with ED and their outcomes after treatment.

Methods 94 HIV positive patients attending our ED clinics from 2006 to 2012 were identified. Data were collected by review of notes and databases. Patients on PIs were started on half of the lowest