dose tablet of PDE5i and titrated upwards if no response. Safer sex was advised.

**Results** Of 94 patients, 58 were Caucasian, 34 black; 58 were men who have sex with men, 35 heterosexual; 65 had a stable partner, 41 (47.8%) had >30 lifetime partners, 25 (26.5%) were >50 years; 36 (38.2%) used recreational drugs. Two were on therapeutic nitrates. Mean CD4 on presentation was 481 (range 35–1558); 60 (63.8%) had an undetectable VL at baseline. 30 (32%) had ED symptoms for >5 years. Risk factors: smokers 35 (37.2%); peripheral neuropathy 8; diabetic 2; abnormal cholesterol 44 (47%); abnormal hormone profiles 4. Sildenafil was the first agent in 55 (59%) patients and tadalafil in 28 (30%). 18 were on "poppers" and were told to stop before starting PDE5i. Improvement was noted in 51 (54%) after the first agent and 68 (72%) after the final agent. 36 (38%) had PDE5i side effects. 39 (41%) was on PI based Antiretroviral therapy. None reported priapism.

**Conclusion** It is safe to treat patients on PI with PDE5i by starting with half of the lowest dose tablet. Treatment of ED improves the quality of life in HIV positive patients but care must be taken to avoid serious drug interaction and safer sex practices should be emphasised.

## P20 POTENTIAL IMPACT OF UPDATED UK GUIDELINES FOR USE OF POST EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE IN A LONDON SEXUAL HEALTH SERVICE

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**Background** Updated UK guidelines for post exposure prophylaxis following sexual exposure (PEPSE) outline new thresholds for when PEPSE is recommended (R), considered (C) or not recommended (NR).

**Aim/Objective** We compared practice and outcomes according to 2006 and 2011 guidelines.

**Methods** Retrospective review of electronic patient records between 20 January 2011 and 7 November 2011. Information regarding presentation, recommendations and outcomes were collected. Risk estimates were compared with guidelines. Blood abnormalities were classified grades I-IV. Data were analysed using Microsoft Excel.

**Results** Of 325 requests to a London sexual health service, PEPSE was issued on 281 occasions to 268 patients. Gender: male n=258, female n=10, median age: 32 years, sexual orientation: men who have sex with men n=236, heterosexual n=25, not recorded n=7. Risk exposure: unprotected anal (n=263) and vaginal (n=26) intercourse. Source details: HIV+ n=112 (40%), on antiretroviral therapy n=31, viral load known 40 (14%) (<50 n=26, >50 n=14). 71 (26%) reported taking PEPSE ≥ once (range 1–5) previously. 99% commenced PEPSE within 72 h (median 30). Comparing those classified as R (n=258) and C (n=21) according to 2006 guidelines, 27 (10%) were reclassified NR using 2011 guidelines. Completion of 28 days PEPSE was reported in 59% cases, 100% adherence in 87%. Eight stopped early due to side effects (n=4) or the source tested HIV- (n=4). 148/268 (55%) had ≥1 blood abnormality, grade I-II (n=196) and grade III-IV (n=29). 1 patient developed acute interstitial nephritis. 196/268 (73%) underwent ≥1 screen for sexually transmitted infections; chlamydia (n=27), gonorrhoea (n=17), syphilis (n=4) and hepatitis B (n=1). Of 243 due 4-month follow-up, 52% have tested HIV− (n=122) and HIV+ (n=4).

**Conclusions** We report high rates of repeat PEPSE, side effects/blood abnormalities and poor completion rates. Updated guidelines may result in a modest reduction in the use of PEPSE.

## P21 POST-EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL ASSAULT

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**Background** HIV post-exposure prophylaxis (PEP) is recommended for survivors of sexual assault. Completion rates are often lower than for PEP prescribed in other settings, which may be related to psychological issues faced by survivors immediately after the assault and a lower threshold for prescribing.

**Aims** To study outcomes of survivors of sexual assault prescribed PEP (Truvada and Kaletra) at an inner city sexual assault referral centre (SARC).

**Methods** Forensic and follow-up notes were interrogated for data on clients prescribed PEP between 1 June 2010 and 31 May 2011.

**Results** Data were available on 54 clients; 46 were female. Median age was 25 (range 14–40 years). Ethnicity: White European 35/54, 11/54 Black African/Caribbean and 8/54 Asian. 48/54 initiated PEP at the SARC, 4 in A&E and 2 in sexual health and all within 72 h. Exposure: 37 RVI, 14 RAI, eight unknown. 20/54 had an additional risk: 11 multiple assailants, eight defloration and seven ano-genital trauma. The assailant HIV status was unknown in all cases, but 11 were assessed to be high risk. 16/54 of the clients had never tested for HIV, 14 had tested negative previously and 24 were not documented. All had PEP prescribed within BASHH guidelines (2006). 36/54 continued care at the SARC. 20/36 (56%) completed 28 days of PEP. Nine were lost to follow-up, four discontinued due to side effects (Grade 1–2 nausea and vomiting), One due to abnormal blood results (Grade 1 rise in ALT and creatinine), one chose to stop and one was not documented. None had their PEP modified. 13/36 had an HIV test at 3 months post-PEP and all were negative.

**Conclusions** This study shows that PEP was prescribed within national recommendations. Completion rates were comparable to a local tertiary sexual health/HIV clinic that followed-up patients prescribed PEP after occupational and sexual exposure (66%) but lower than the 2006 BASHH standards (75%). This suggests that survivors of sexual assault may require greater adherence support.

## P22 A USER CENTRED APPROACH TO THE DESIGN OF P-OF-CARE AND SELF-TEST MOBILE PHONE DIAGNOSTICS FOR SEXUALLY TRANSMITTED INFECTIONS (STIS)

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**Background** Effective Sexually Transmitted Infection (STI) control is being challenged by inadequate access to prompt diagnosis and treatment for patients and relatively poor community STI surveillance. This work forms part of a larger eSTI$^2$ (Electronic Self-Testing Instrument for Sexually Transmitted Infections) consortium developing diagnostic devices for pathogen detection and integrating point-of-care tests with mobile technology.

**Aim(s)/Objective(s)** Harnessing the widespread mobile phone use, this research develops innovative eSTI$^2$ technologies for reducing STIs transmission and providing greater personal control of sexual health. The aim of this study is to develop a wireless web-based management system that links chlamydia self-test diagnostics to further patient care pathways.

**Methods** This research adopts a user centred approach to the development of a Human Technology Interface for self-managing STI diagnosis. The research methodology begins primarily with initial exploratory pilot studies to gather functional and user requirements regarding ethical and regulatory requirements of the Human Technology Interface. Iterative development of functional prototypes

exploring design possibilities and technology features will be followed by the formative evaluation of interface design through qualitative and controlled usability studies with target users.

**Results** In this paper we report on a user centred approach that allows for the successful capture and integration of social science methods to encapsulate user requirements with usability principles in order to develop an effective and user acceptable self-managing STI system.

**Discussion and/or Conclusions** Working in a cross-discipline collaboration the overall aim is to investigate the impact of user-centred methods in the design of innovative mobile phone and web technology based rapid testing.

## P23 'THIS IS A POLICY NOT A PILOT': HOW TO IMPLEMENT ROUTINE OPT-OUT HIV TESTING FOR ACUTE MEDICAL ADMISSIONS IN AN NHS TRUST IN A HIGH PREVALENCE AREA

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**Background and Aims** Feasibility and acceptability of HIV testing in acute medical settings has been demonstrated in pilot studies. Whereas we report our success of embedding HIV testing in routine clinical care, delivered and sustained by medical staff in an NHS trust.

**Methods** From July 2011 all patients aged 16–79 years, attending the Acute Medical Unit (AMU), have had a standard HIV test unless they decline. Laboratory costs are funded by the local NHS. Literature was produced for staff and patients. Verbal consent and test ordering is carried out by general medical doctors and AMU nurses, all had training by the local HIV team. AMU proformas were updated with sections for HIV test offer and reason for refusal. The HIV team made regular AMU visits to motivate, troubleshoot and feedback progress. From the outset, nurses were more proactive than doctors in applying the policy. Building on their enthusiasm, nurses were empowered so that by October 2011 AMU visits were weaned as nurses took the lead to enforce the policy.

**Results** 3709 attendees in the first 6 months, median age 57 years, 50% female, 54.7% Caucasian, 6% Black African. 1390 (37.5%) had samples for HIV testing; their demographic profile is comparable to that for all attendees. HIV test rate went from 33.2% July–September to 41.3% October–December ($p<0.005$ $\chi^2$). For a random sample (n=396), HIV test uptake was 84%. Detailed analysis on offer rate and factors associated with uptake will be presented at the conference. Seven new HIV diagnoses were made, all but one had CD4 >200.

**Conclusion** A routine opt-out HIV testing policy can be delivered by frontline medical staff in an acute setting with no extra resource requirement beyond laboratory costs. Such a policy identifies new HIV patients who would not otherwise have tested and reduces late diagnosis. We believe that policy ownership by nurse champions, with the HIV team as background advisors, is key to achieving and sustaining high test rates.

## P24 REGIONAL EXPERIENCE OF INDICATIONS FOR SWITCHING PATIENTS TO RALTEGRAVIR AND MARAVIROC AND SUCCESS AFTER REGIMEN CHANGE

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**Background** In small centres there is wide variation in the accessibility of raltegravir (RAL) and maraviroc (MVC) as they are not on the formulary of several trusts. Individual PCT funding is sought on a named patient basis, a time consuming process leading to potential delays in treatment.

**Objectives** To identify common clinical indications for treatment change to RAL or MVC. To formulate prescribing criteria on the basis of these in order to seek approval from the District Prescribing Committee and streamline treatment provision.

**Methods** Retrospective case note review of patients started on RAL or MVC attending six HIV clinics within a regional network between 2008 and 2010 and collection of data on reasons for treatment change.

**Results** 40 patients were reviewed, 37 of whom started RAL and 3 MVC. Multiple factors contributed to therapy change. 22 patients (55%) had resistance to other antiretrovirals or treatment failure and 20 (50%) had significant side effects or intolerance to other drug classes. Other factors included cardiovascular risk (20%), co-infections (18%) and co-morbidities (18%). 14 patients were reviewed for immunological response following treatment. Two were excluded (one unrelated death). Of the remaining 13 patients, 46% had a suppressed viral load prior to starting RAL, and 92% were suppressed after 12 months of treatment.

**Conclusions** This study demonstrates that identifying common indications for switching to RAL and MVC within a regional network supported the process of formulating criteria to prescribe these newer drugs. This unified approach within the region led to improved and timely access to these drugs thereby improving outcomes for patients at small centres. The agreed prescribing criteria were in instances where combination therapy was not possible due to intolerability, side effects, allergies, resistance, drug interactions, co-morbidities, or HIV-2 (for RAL).

## P25 EPIDEMIOLOGICAL TREATMENT FOR CHLAMYDIA CO-INFECTION IN MSM WITH A PRESUMPTIVE DIAGNOSIS OF URETHRAL GONORRHOEA IN S. AUSTRALIA

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**Background** Rates of up to 30% *Neisseria gonorrhoeae* (NG) and *Chlamydia trachomatis* (CT) co-infection occur in men. Historically, Men who have Sex with Men (MSM) were considered to have a low incidence of CT. However, increasing prevalence of CT and NG in MSM, especially asymptomatic anorectal infection is a reality. Despite well-established guidelines providing presumptive co-treatment for CT to patients with treatment indications for NG, various centers in Australia differ in their approach to management in MSM. At our Clinic, epidemiological treatment for CT had only been given to heterosexual males with a presumptive diagnosis of urethral gonorrhoea.

**Aim** This study was to determine if the local prevalence of CT co-infection in MSM justifies epidemiological treatment when a presumptive diagnosis of urethral gonorrhoea is made.

**Methods** A retrospective review of case notes data, analysed for NG and CT co-infection in male patients was made over a 10-year period from 2001 to 2010. Data analysis was performed using STATA (V.10).

**Results** The proportion of heterosexual males who were NG smear positive and also found to be CT positive was 33/274 (12%) CI 8.4% to 16.5%. The proportion of MSM who were NG smear positive and found to be CT positive as well was 22/207 (13.4%) CI 9% to 18.8%.

**Conclusion** Based on this study, the guidelines at our Clinic were changed. All MSM with a presumptive diagnosis of NG infection are now given epidemiological treatment for CT infection as heterosexual men.