Methods Treatment naïve HIV-1+ adults were randomised 1:1 to a single tablet regimen of E/C/F/TAF or E/C/F/TDF once daily in two double blind studies. Assessments for all subjects included measures of glomerular and proximal renal tubular function, and bone mineral density (BMD). Four pre-specified secondary safety endpoints were tested: serum creatinine, treatment-emergent proteinuria, spine and hip BMD. Week 48 off-target side effects data are described.

Results 1,733 subjects were randomised and treated. Plasma TFV was >90% lower (mean AUC_{tau} 297 vs. 3,410 ng·hr/mL) in the E/C/F/TAF arm, compared to the E/C/F/TDF arm. Serum creatinine (mean change: +0.08 vs +0.11 mg/dL, p < 0.001), quantified proteinuria (UPCR, median % change; -3 vs +20, p < 0.001), and fractional excretion of phosphate (median % change; +0.9 vs +1.7), all favoured E/C/F/TAF. There were no cases of proximal tubulopathy in either arm. Mean% decrease in BMD was significantly less in the E/C/F/TAF arm for both lumbar spine (−1.30 vs −2.86, p < 0.001) and total hip (−0.66 vs −2.95, p < 0.001).

Conclusions Through 48 weeks, subjects receiving E/C/F/TAF had significantly better outcomes related to renal and bone health than those treated with E/C/F/TDF;. These data demonstrate important safety benefits of TAF relative to TDF, especially given the ageing of the HIV population and the need for long-term treatment.

P100 **TENOFOVIR ALAFENAMIDE (TAF) IN A SINGLE TABLET REGIMEN IN INITIAL HIV-1 THERAPY**

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Background Tenofovir alafenamide (TAF) is a novel tenofovir (TFV) prodrug that, when administered in the single tablet regimen E/C/F/TAF, has >90% lower plasma TFV levels compared to tenofovir disoproxil fumarate (TDF).

Methods Treatment naïve HIV-1+ adults were randomised 1:1 to receive a regimen of E/C/F/TAF or E/C/F/TDF in two Phase 3 double blind studies. Primary endpoint was Week 48 virologic response by FDA Snapshot algorithm in a pre-specified combined analysis.

Results 1,733 subjects were randomised and treated: 15% women, 43% non-White, 23% viral load ≥100,000 copies/mL. The primary objective was met, E/C/F/TAF was non-inferior to E/C/F/TDF with 92% and 90%, respectively having HIV RNA <50 copies/mL at week 48 (difference +2%, 95% CI -0.7% to +4.7%, p = 0.13). Virologic failure with resistance occurred in 0.8% in the E/C/F/TAF arm and 0.6% on E/C/F/TDF. Treatment related SAEs were rare: E/C/F/TAF 0.3% (n = 3), E/C/F/TDF 0.2% (n = 2). There were no reports of proximal renal tubulopathy in either arm. No single AE led to discontinuation of more than 1 subject on E/C/F/TAF. Grade 2, to 4 AEs occurring in ≥ 2% were: diarrhoea (3.3% vs. 2.5%), nausea (2.2% vs. 2.0%), headache (2.9% vs. 2.1%), and URI (3.6% vs. 3.1%) in the E/C/F/TAF vs. E/C/F/TDF arms.

Conclusions Through 48 weeks of treatment, high virologic response rates were seen in patients receiving E/C/F/TAF or E/C/F/TDF. Both regimens were well tolerated, and no unique AEs associated with TAF occurred. These data support the use of E/C/F/TAF, as a potential regimen for initial treatment of patients with HIV-1 infection.

P101 **HOW SOON ARE PATIENTS TESTING OUTSIDE GUM RECEIVING A POSITIVE HIV RESULT?**

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Introduction UK national guidelines for HIV testing 2008, recommend that any individual testing positive for HIV should see a specialist preferably within 48 h and certainly two weeks of receiving the result.

Methods All HIV positive test results performed outside the GUM clinic between January 2013 and December 2014 were obtained from the microbiology database at Frimley Park Hospital. 35 patients were identified. 20 were excluded because they were previously known to have HIV, had a "non-specific" or "weakly reactive" result.

Results Of the 15 new diagnosis, 8/15 were inpatients, 4/15 outpatients and 3/15 GP diagnosis. Two-thirds were male, 53% White British and 73% heterosexual. The average age was 46 (31–65) years. All the patients had a fourth generation HIV test and a confirmatory test. The majority (87%) were late diagnosis with symptomatic HIV/AIDS and an average CD4 count of 50 cells/mm³. One inpatient diagnosis was missed for 5 weeks until the patient re-presented with PCP. The rest were all seen by a specialist (HIV consultant or health advisor) within 2 weeks of receiving their diagnosis with 64% seen within 24–48 h.

Discussion/conclusion The majority were late, symptomatic patients with AIDS. All but one result which was initially missed were seen by a specialist within the recommended 2 to 14 days after diagnosis. The recommendation now is that all positive results are phoned to the named consultant/GP responsible for the patient as well as the HIV/GUM team.

Category: Improving clinical practice and service delivery

P102 **WHY DO PATIENTS ATTEND AS REBOOK ATTENDEES IN SEXUAL HEALTH CLINICS?**

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Background/introduction Locally commissioners have raised concerns as regards the number of patients re-attending as a new episode of care (rebook) at the countywide sexual health clinics, rebook patients accounting for 54% of new/rebook attendances over a three month period. Commissioning concerns focussed on whether re attendance for recurrent bacterial sexually transmitted infections (STIs) due to previous suboptimal health prevention/promotion. Are there any grounds for these concerns?

Aim(s)/objectives To ascertain the reasons why patients re-attend clinics as rebook patients.

Methods A retrospective analysis of 150 case notes of rebook patients was undertaken with respect to age, gender and reasons