

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 $\geq 100,000$ 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 $\geq 2\%$ 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

for attendance. In addition a questionnaire survey was administered prospectively to 172 rebook patients as regards reasons for re-attendance.

Results In the retrospective study, 106/150 (71%) were female, the average age of males was 30.4, the average age of female was 23.9. 56% (84/150) of patients attended three times or more related to genital warts, genital herpes, pelvic pain, contraception or recurrent bacterial vaginosis. In the prospective survey, 24% stated that they had re-attended because of genital warts, recurrent genital soreness or pelvic pain. 73/172(42%) were asymptomatic. Between 48–63% stated they preferred to attend because of the expertise, friendliness and confidentiality of the clinic.

Discussion/conclusion In one study, 56% of attendees had attended with recurrent issues not related to recurrent bacterial STIs. Between 48–63% had attended related to friendliness, expertise and confidentiality of the clinic inferring that quality of care and confidentiality are important factors in reasons for re-attendance.

P103 HOW AND WHY DO WE DO TESTICULAR ULTRASOUNDS? A NATIONAL CLINICAL DEVELOPMENT GROUP SURVEY OF GENITOURINARY MEDICINE CLINICS

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Background/introduction There is a paucity of guidelines for when testicular ultrasound (USS) should be performed and how easily GUM clinics should be able to access scans.

Aim(s)/objectives To establish what pathways are in place for USS requests and clinical prompts to order a scan.

Methods A 10 question survey was designed using Survey Monkey. This was approved by the BASHH Clinical Development Group, and disseminated within the network via the regional representatives.

Results The link was sent to 139 leads and completed by 111 clinics (79%). The majority of respondents (92.79%) had USS located in hospital. 72.97% services had no guidelines and 48.18% had no pathway for urgent scans. 77.48% requested between 1–6/ USS month. No service had to wait > 2 weeks for urgent requests, with 23.85% services having same day access. Ranking for symptoms and signs showed 62% services would often/ always scan for a mass present >14 days, and 92.79% always scan a hard, painless testicular mass.

Discussion/conclusion The majority of services have access to timely USS, although half do not have established pathways for urgent scans. The most concerning clinical features are the persistence of swelling and mass consistency, but for other features, such as pain, respondents felt that further information is required. In general, patients are relying on clinical judgment of experienced clinicians to decide the need for requesting scans. With integration of practitioners with different skills, there is need for a more standardised approach for how, when and why we perform testicular ultrasounds.

P104 PATIENT STORIES: WHAT CAN WE LEARN FROM LISTENING TO HEALTHCARE WORKERS WITH HIV

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Background/introduction Issues faced by healthcare-workers (HCW) with HIV are complex. HIV positive individuals continue to experience unacceptable levels of health related stigma. National HIV testing week offers a perfect platform to raise the profile of HIV within our hospital Trust.

Methods HIV positive healthcare workers were approached and asked to write an account of their experiences of testing, living and working with HIV and whether they had chosen to disclose their status to colleagues and the outcome of that experience. Key themes were extracted from the stories.

Results Six healthcare workers living with HIV, on treatment, in care, agreed to share their stories. Key themes from the stories were: missed opportunities for HIV testing pre-diagnosis, misdiagnosis and misunderstanding of HIV from HCW, feeling judged and experiencing prejudice from HCW, loss of professional confidence due to negative attitudes towards HIV/AIDS from HCW, delayed or non-disclosure of HIV status due to experiencing negative comments or behaviours towards HIV in clinical settings: however HCW who disclosed their status at work experienced significant support and empowerment, including a desire to teach and train HCW. Patient stories were used in HIV testing week to promote testing as part of a larger HIV-awareness campaign.

Discussion/conclusion Engaging HIV positive healthcare workers as part of a strategy to increase awareness of HIV in healthcare settings is empowering for patients and a powerful message to colleagues.

P105 SEXUAL HEALTHCARE PROFESSIONALS' ATTITUDES TOWARDS HPV VACCINATION FOR MEN IN THE UNITED KINGDOM

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Background/introduction Men who have sex with men (MSM) are at risk of HPV-associated genital warts and cancers but are unlikely to benefit from female-oriented HPV vaccination.

Aim To examine the attitudes of sexual healthcare professionals (SHCPs) towards HPV vaccination of men in the UK.

Methods An e-survey of SHCPs' views was conducted in July–August 2014. Members of UK-based professional sexual health associations were invited to participate by direct email and members' newsletters. Responses to 18 statements, with corresponding Likert scales, were used to examine their views on HPV vaccination.

Results Amongst 325 respondents (46% Doctors, 26% Nurses and 15% Health advisors), 14% are already vaccinating men against HPV and 83% would recommend gender-neutral HPV vaccination. While 64% would also recommend targeting MSM,