P089 PJP DIAGNOSIS IN THE HAART & PCR ERA

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Introduction In the HAART era, Pneumocystis jirovecii Pneumonia (PJP) continues to be a major opportunistic infection. PJ PCR is increasingly available to support the diagnosis of PJP. A 'low level' PCR result may represent PJ colonisation or a poor-quality specimen. Upper airway samples such as throat swabs (T/S) are also more likely to yield a negative or low level positive.

Method Retrospective review of all HIV-infected adults with respiratory tract PCR-confirmed PJP and pneumonia over an 18 month period. Demographics, clinical features, management, clinical outcome and laboratory parameters were recorded.

Results 4/12 patients had negative T/S PJP PCR test before the diagnosis was confirmed. The mean cycle threshold (CT) value for throat swabs was *34.04*. The mean CT value for sputum was *32.05*.

Discussion PJP PCR is a useful investigation. PCR will detect more cases than traditional tests (direct organism visualisation). This leads to earlier PJP treatment and earlier screening for HIV. While there is a trend towards lower CT value results in sputum when compared with throat swabs, any positive PJP result should trigger the offer of a HIV test. Patients with a negative URT PCR and clinical suspicion of PJP should receive empiric treatment and where appropriate proceed to BAL, as per national guidance.

P090 FORMALISED LOOK-BACK IN NEWLY DIAGNOSED HIV TO IDENTIFY MISSED OPPORTUNITIES IN OTHER CLINICAL SETTINGS: FIRST GET OUR OWN HOUSE IN ORDER!

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Introduction HIV late diagnosis is one of three key indicators on sexual health in the Public Health Outcomes Framework. The British HIV Association (BHIVA) Standards of Care for People Living with HIV advocates the use of 'look backs' in the case of late and very late diagnosis of previous engagement with health care services to identify missed opportunities and areas for shared learning and development.

Methods Further to the look-back exercise undertaken on late and very late diagnoses presenting 2012–2016, we extended the use of the standardised look-back tool to ALL new diagnoses from late 2016 onwards.

Results In addition to anticipated missed opportunities being identified in the late and very late presentations, we identified 2 missed opportunities in much earlier presentations from within our own service! They related to failure to repeat the HIV test at test of cure (TOC) for gonorrhoea and subsequent Hepatitis vaccination appointments. In both cases the initial negative HIV test had been within the potential window period.

Discussion As a result of the look-back exercise we have learnt a valuable lesson about the fallibility of our own service and shared the learning within our multi-disciplinary team. We

Abstract P089 Table 1 Patients with PJP (in order of immunosuppression)

Age at HIV diagnosis, gender, behavioural risk	Category	CD4+ count at PJP diagnosis, PJP severity	PJP test 1 (Ct value, site)	PJP test 2 (Ct value, site)	Clinical outcome
	Known HIV				
39/M/IDU	On ART for 4 weeks, not on PJP prophylaxis	200, mild	37.0, TS	n/a	Survived
38/M/MSM	Defaulted from care, not on ART	10, severe	Neg., TS	32.5, TS	ICU care, survived
	Missed opportunity to diagnose HIV				
53/M/MSM	Unexplained diarrhoea and weight loss	70, severe	30.0, SPU	26.2, SPU	ICU care, deceased
43/F/heterosexual	Unexplained lymphadenopathy and weight loss	50, severe	26.4, SPU	Neg., TS	Readmitted with hypoxia, survived
32/F/heterosexual	Campylobacter gastroenteritis	50, severe	36.4, TS	25.3, SPU	ICU care, survived
56/M/unknown	–	30, severe	Neg., TS	31.5, SPU	ICU care, deceased
39/M/heterosexual	Unexplained weight loss	20, mild	Neg., TS	25.0, SPU	Survived
62/M/MSM	Unexplained weight loss	20, mild	26.0, BAL	n/a	Survived
55/M/MSM	Bacterial pneumonia	20, mild	33.0, SPU	n/a	Survived
52/M/heterosexual	–	10, severe	30.3, SPU	34.9, SPU	ICU care, survived
57/M/MSM	Unexplained weight loss	10, severe	39.0, SPU	n/a	ICU care, survived
52/M/heterosexual	Chronic diarrhoea, bacterial pneumonia	0, severe	Neg., SPU	28.0, SPU	ICU care, hypoxia requiring long-term home-O_2

Note- **BAL** broncho-alveolar lavage; **F**: female; **M**: male; **ICU**: intensive care unit; **IDU**: intravenous drug user; MSM men who have sex with men; **n/a**: not available; **Neg.**: PCR not detected; **SPU**: sputum, **TS**: throat swab
PJP severity ('mild': mild-moderate, or 'severe': moderate-severe, by BHIVA criteria)

have encouraged all to remember to re-visit the sexual history and timing of sex in relation to testing at 'quickie' follow up visits for vaccination or TOC and repeated education about window periods.

We shall continue to utilise the look-back tool in all new HIV presentations and encourage colleagues to do likewise to maximise on identifying learning opportunities.

P091 NEW HIV DIAGNOSES AMONG WOMEN IN A LARGE TEACHING HOSPITAL

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Introduction In 2014 there were an estimated 103,700 people living with HIV (PLHIV) in the UK, approximately one third were women. In 2015 there were 965 PLHIV in our cohort, 215 were women. There are few data available on HAART in women, other than in pregnancy. Socio-economic and cultural factors may also affect their ability to access care. Other factors affecting women include contraception, conception and pregnancy.

Methods A retrospective chart analysis was carried out on all new diagnoses among women over a 3-year period, from April 2013 to April 2016. Patients who had previously been diagnosed elsewhere were excluded.

Results There were 286 new diagnoses of HIV in this period; 44 (15%) were women. 41% of patients were local, 39% were of African origin. 57% of patients were diagnosed late, having CD4 <350 at diagnosis. 8 patients were pregnant; there were no vertical transmissions. Existing children were tested were possible; no positive diagnoses were made. A number of male partners were diagnosed through partner notification. The majority of patients commenced HAART and reported good adherence.

Discussion Women make up a significant proportion of PLHIV, though rates in our region are lower than in the rest of the UK. The majority of positive women in the UK are of black African origin, though in our cohort a higher proportion were born locally. Many of these women are diagnosed late, and with no identifiable traditional risk factors. There are a number of important gender-specific factors associated with HIV-positive women and these should not be underappreciated.

P092 NATIONAL HIV TESTING WEEK 2016: INCREASING HIV AWARENESS AND TESTING OPPORTUNITIES THROUGH A COORDINATED NATIONAL EVENT

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Introduction National HIV Testing Week (NHTW) is an annual event co-ordinated by HIV Prevention England (HPE) which aims to increase HIV testing in England, as well as to increase awareness and acceptability of HIV testing among key populations. It takes place each November in the lead-up to World Aids Day.

Methods Digital and print promotion of: the event and postal testing services, as well as digital interactive information tools which seek to reduce barriers to testing. Provision of printed resources, including customizable and community-language posters to promote local testing events. A post-event evaluation to assess the effect of the campaign was also completed by the organisations involved.

Results For NHTW 2016, 100 organisation representatives responded to the post-event evaluation. 65% agreed that NHTW increased their capacity to impact their community/clients. The biggest impact was through increasing awareness of the importance of HIV testing in the local community (86%), followed by delivering more HIV tests (57%). Of those organisations who provide HIV testing, 33% provided at least twice as many tests in testing week compared with a regular week.

Nearly 320 organisations ordered 400,931 NHTW resources. 211 testing events were registered on the website and 5,740 HIV home-sampling kits were ordered by the public, driven by social media and mobile app advertising.

Discussion NHTW is a high-impact event which promotes HIV testing, uniting community, clinical, government and statutory stakeholders. The campaign in the future will hope to engage more partners and keep amplifying local HIV testing and raising awareness.

P093 HIV TESTING FOR HOSPITAL INPATIENTS IN A PRIORITY AREA

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Introduction Department of Health advises that HIV testing should be routinely offered to patients in priority areas; where prevalence ≥1–2/1000, such as Brighton. We sought to increase HIV testing in the Cardiology department. Local microbiology department advises HIV testing on all inpatients with suspected or proven infective endocarditis (IE), as such we investigated testing in this group.

Aim Assess the proportion of patients with suspected or proven IE offered a HIV test at baseline, and following an intervention to promote testing.

Methods Patients with IE are discussed at a weekly multi-disciplinary team (MDT). We retrospectively reviewed MDT meetings from June – November 2016 (cycle one). Data on HIV testing were extracted from MDT proforma and hospital results system. Initial results were presented to cardiology junior doctors and testing encouraged. We prospectively reviewed MDT meetings and HIV testing in the 10 weeks after the intervention (cycle two).

Results In cycle one, 29 patients (25 males, 4 females) had suspected or proven IE, 16 (55%) were tested. In cycle two the proportion of patients tested for HIV decreased; of the 8 patients with suspected/proven IE (6 males, 2 females); 2 (25%) were tested, 6 (75%) were not.

Discussion HIV testing rate decreased by 46% between cycles, representing multiple missed opportunities for testing. The reason for this trend is not clear but barriers to HIV testing remain, including poor awareness of indications to test, uncertainty around consent, and assumption of low risk. We plan further interventions to increase HIV testing locally.