P094 IMPACT OF AN HIV EDUCATIONAL PROGRAM ON RATES OF LATE HIV DIAGNOSIS IN AN AREA OF HIGH PREVALENCE

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Introduction Late HIV diagnosis is an important determinant of morbidity and mortality. An audit of new HIV diagnoses in our service based an area of high prevalence, showed high rates of late diagnosis in 2012, so an HIV education programme was implemented within the Trust. We re-audited new diagnoses in 2015 to look at the impact of the programme and compared the results.
Methods A retrospective case-note review of all newly diagnosed patients seen in our HIV clinic from 1st January 2015 – 31st December 2015.
Results 53 patients were identified in comparison to 56 in 2012, of which 64% were male compared with 55% in 2012. Median age was 41.5 years (range 21 – 68) compared with 39.5 years (range 20 – 64) in 2012. 53% were diagnosed with a CD4 count <350 cells/mm^3 compared with 63% in 2012 and 34% had a CD4 count <200 cells/mm^3 compared with 45% <200cells/mm^3 in 2012. 51% had been seen in the preceding year by doctor, compared with 52% in 2012. 49% were diagnosed in a sexual health service compared with 39% in 2012.
Discussion Our re-audit showed continued high rates of late diagnosis despite a dedicated educational programme. This suggests that education alone is not sufficient to cause a sustained impact on late diagnosis rates. HIV testing needs to be embedded in routine clinical care, such as opt out testing as advised in UK national testing guidelines, or by using pathology system alerts to suggest testing if blood results are indicative.

P095 LATE DIAGNOSIS OF HIV IN NORTHERN IRELAND

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Introduction Late HIV diagnoses (CD4 count <350 cells/mm^{3}at diagnosis) across UK declined from 57% (2004) to 39% (2015) however a review within our region in 2013–14 revealed much higher proportion of late diagnoses than UK average, with multiple missed opportunities for testing in majority cases. Data was presented at educational meetings and feedback given to clinicians when delay in diagnosis occurred. We sought to assess impact on late diagnoses and mortality within our population.
Methods Retrospective chart analysis of new diagnoses from March 2015–February 2016 (Period 2) to determine proportion of late diagnosis, missed opportunities for testing and mortality. Comparison made with results of previous review during July 2013–June 2014 (Period 1).
Results 76 new diagnoses during period 1; 71 in period 2. Late diagnosis decreased from 59% (45/76) to 49% (35/71). Proportion diagnosed through GUM increased from 20% to 34%. Remainder diagnosed in other specialities, most commonly general medicine. Mode of transmission in period 1 and 2 respectively; MSM 49% vs71%, heterosexual 47% vs 23%, IVDU 7% vs 11%. Prior to diagnosis, number patients presenting to other settings with clinical indicator diseases significantly decreased from 84% (38/45) in period 1 to 49% (17/35) period 2. Mortality more than halved from 7% (4/45) in period 1 to 3% (1/35) period 2.
Discussion While there has been a decrease in number of late diagnoses and mortality rate, the proportion being diagnosed late remains higher than other UK regions. Opportunities for early testing are still being missed and ongoing education required.

P096 HIV TESTING IN TERTIARY HEALTHCARE SETTINGS – STAFF BELIEFS AND CONCERNS

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Introduction Undiagnosed HIV remains a problem in the UK. Locally, we have an extremely high prevalence of HIV (>8:1000). BASHH, BHIVA and NICE recommend routine HIV testing in medical admissions in areas of high prevalence. We wanted to identify current practices and knowledge of HIV testing in our large acute urban hospital trust.
Methods An electronic survey of clinical staff was distributed via email and Trust website in November 2016.
Results 42 responses were collected from 21/42(50%) nurses, 6/42(17%) medical staff and 15/42(36%) other staff. 33/42 of responses were from non-traditional settings (non-GUM, HIV, ID). 39/42(93%) agreed that HIV testing should be part of regular healthcare and most (32/42(76%)) agreed that it does not interfere with other healthcare services and (24/42(57%)) that they have the resources to perform a test 30/42 (75%) feel comfortable in discussing HIV with patients and 20/42 (71%) feel comfortable in offering and performing an HIV test. 18/42(43%) said they believed patients would be offended by offering an HIV test. 14/42(34%) do not know if patients receive adequate pre-test information, while 20/42 (48%) said patients are not receiving adequate post-test information. 17/42 (41%) do not know if test results are being given in an appropriate and confidential manner to patients.
Discussion Overall clinical staff believe that HIV testing is a good idea and does not interfere with the provision of regular health care services. However the clinical teams offering tests need more information on what pre and post-test discussion is required and how patients receive results.

Improving Clinical Practice and Service Delivery

P097 ABSTRACT WITHDRAWN

P098 EVALUATION OF THE PERFORMANCE OF HCV AG IN ROUTINE SCREENING FOR HEPATITIS C IN HIGH-RISK POPULATIONS

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Introduction Screening high-risk populations for hepatitis C (HCV) using antibody (anti-HCV) does not immediately distinguish resolved and active infections and may miss acute infections. HCV core-antigen (HCVAg) screening has been introduced in laboratories supporting some UK sexual health clinics. We evaluated Abbott Architect's automated HCVAg immunoassay for HCV screening.

Methods Testing was introduced in May 2015 for those reporting HCV risk in the past 6 months, and annual screening for all HIV-positive individuals. HCVAg-positive samples were tested in duplicate, then tested for HCV–RNA. Few samples were tested for both HCVAg and HCV-RNA in the initial few months. Results for all tests performed May 2015–April 2016 were reviewed.

Results 5132 samples were tested for HCVAg. 113/5132(2%) were HCVAg positive. 139 samples had both HCVAg and HCV-RNA tested. Using HCV-RNA as the gold standard, HCVAg sensitivity was 99%; positive predictive value 63%. Specificity was 39%; negative predictive value 96%.

Abstract P098 Table 1 Evaluation of HCV Ag test

	HCV-RNA detected	HCV-RNA not detected
HCVAg+ve	71	41**
HCVAg-ve	1*	26

The HCVAg negative/HCV-RNA positive individual had low viral load (130c/ml).

Of the 41 HCVAg positive/HCV-RNA negative individuals; 30(73%) were retested later and were HCVAg negative and HCV-RNA or anti-HCV negative. 3(7%) were persistently HCVAg positive but HCV-RNA negative; 7 had no follow up samples; 1 subsequently became HCV-RNA positive.

Discussion The specificity of HCVAg in our cohort is lower than that published in a recent systematic review (93% sensitivity/99% specificity). False positive results cause distress for patients and additional laboratory costs, however the increased sensitivity for acute infection may lead to earlier diagnosis in high-risk populations.

P099 TV OR NOT TV: USING NAATS TO IMPROVE THE COST EFFECTIVENESS OF TESTING

Audit of the management of patients with trichomonas vaginalis, using nucleic acid amplification technique (naat) testing in a high tv prevalence area

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Introduction In April 2016, we changed from TV culture to BD Viper NAATs testing and from testing all women to only testing women who were symptomatic, STI contacts, had previous TV and male contacts of TV.

Methods Laboratory data and SHHAPT codes retrospectively identified all patients diagnosed with TV between 1 May – 30 November 2016. Electronic patient records (EPR) were reviewed and data analysed in Excel.

Results There were 96 new diagnoses, 93 females and 3 males, median age 31 (IQR 24–40). 66% Black Afro-Caribbean; 3 were sex workers. 91% symptomatic, 22% had STI co-infection, 26% bacterial vaginosis, 7% candida and 32% previous TV.

Wet prep microscopy (WPM) detected 65% of symptomatic cases. Treatments were Metronidazole or Tinidazole.

The audit standards our service achieved (BASHH performance standards target- 97%) were: 100% received appropriate antibiotics, 51% written information receipt documented, 90% had partner notification recommended (PN) and 28% PN confirmation.

Abstract P099 Table 1 Cost analysis summary

	2015 (Culture)	2016 (NAATs)
Tested	3054	1859
Positive	84	117
New infections	73	96
Cost	£19,851	£15,486

Discussion TV NAATs cost more than culture but changing our protocol reduced the overall cost while increasing the number of new diagnoses; enabling us to target testing to patients at highest risk. 35% (27) were missed on WPM. 9.3% (9) were asymptomatic and detected because of testing as contacts of TV/sex worker/cervical cytology detection. Recommendations include: staff training to improve completion of PN and modifying our EPR fields to improve documentation of leaflets having been given.

P100 PRIME: A WEB-BASED HIV RISK REDUCTION PACKAGE FOR HIGH-RISK MSM

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