Background/introduction National standards recommend eighty percent of new sexual health patients should have an HIV test. Thames Valley data from 2013 highlighted lower uptake of HIV testing in the region's only integrated sexual health service (SHS) compared to two local non-integrated services.
Aim(s)/objectives This audit measured differences in HIV testing uptake between genitourinary (GU) and contraception consultations in an integrated SHS and assessed the impact of a publicity campaign.
Methods SHHAPT codes and demographics were collected from all *new* patients over two weeks; non-coded patients were excluded. Retrospective case-note review differentiated GU from contraception presentations. 'National HIV testing week' posters were displayed in week 2. Data were analysed in Microsoft Excel.
Results Total sample size was 205 patients (week 1, N = 114, week 2, N = 91). 63% were female and 96% heterosexual. Age range was 14 to 83 (mean 31, standard deviation 13), with 36 countries of birth. Patients presented for GU issues (N = 126; 61%), contraception (N = 67; 33%) and combined (N = 12; 6%). HIV uptake differed between GU and contraception groups (81% v 30%). Between weeks 1 and 2, testing uptake increased by 4.5% in the total population and 10.6% in the GU group with minimal change in the contraception group.
Discussion/conclusion HIV testing uptake is higher in GU presentations compared to contraception presentations. This large discrepancy impacts overall testing figures. A publicity campaign may have increased GU uptake but had no impact on contraception consultations. Targeted education and opt out testing should be considered in integrated services.

P94 MORTALITY IN HIV POSITIVE PATIENTS IN A LARGE INNER CITY TEACHING HOSPITAL

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10.1136/sextrans-2015-052126.137

Background/introduction With the advent of highly active antiretroviral therapy (HAART) mortality among HIV positive patients has fallen significantly. Mortality review is important to target care and interventions appropriately.
Methods We reviewed mortality data from 2013 to 2014 for patients under the care of the HIV team at an inner city teaching hospital. There were 39 deaths in our cohort of 3400 patients.
Results Our cohort matched demographic data for people living with HIV in the UK in most respects: male to female ratio was approximately 7:3, 56% were Caucasian, 33% Black African. 21% of patients had acquired HIV via intravenous drug use (although only 2% of people living with HIV nationally are drug users). 28% were men who have sex with men. The median age of death was 47. The most common cause of death was malignancy (44%) followed by sepsis and ischaemic heart disease. Those with a CD4 count <200 at diagnosis survived on average 5.7 years before death. Those with a CD4 count >200 at diagnosis survived 9.7 years on average.
Discussion/conclusion In the post-HAART era, the majority of deaths in people with HIV are not HIV related. Nine patients, however, had an AIDS defining malignancy and three had active opportunistic infections. In the era of HAART, screening for chronic disease and malignancy is vital. Our data suggest that intravenous drug use is a significant factor in people dying at a younger age with HIV. There remains a correlation between late diagnosis and increased risk of death.

P95 THE ABILITY OF THE ALERE™ HIVCOMBO POINT-OF CARE TEST TO DETECT ACUTE HIV INFECTION

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Background/introduction Detection of acute HIV infection is important in preventing HIV transmission and for consideration of early antiretroviral therapy. Fourth generation (4G) HIV tests detect p24 antigen and HIV antibody and should detect acute HIV infection prior to the development of antibodies. An early version fourth generation (4G) point-of-care (POCT) test demonstrated low levels of sensitivity for p24Ag.
Aim(s)/objectives To assess the ability of the new Alere™ HIV Combo 4G POCT to detect p24 antigen in patients with laboratory confirmed p24 antigenaemia.
Methods P24 antigen positive serum samples were tested using the Alere™ HIV-Combo POCT and read at 20 and 40 min. One sample gave an invalid result and was excluded. P24 antigen levels from the VIDAS quantitative HIV p24 11 assay, used as routine HIV confirmatory tests by our laboratory, were recorded for comparison.
Results Twenty-four out of 27 samples (89%) were p24 antigen positive at 20 min and 25/27 (93%) samples were positive at 40 min. There were two false negative samples, shown to have the lowest levels of p24 antigen (27.6 and 8.3 pg/ml) of the 27 samples. The mean p24 antigen level with the VIDAS quantitative HIV p24 11 assay for the cohort was 236.2 (Range 8.3->400 pg/ml). The Alere™ HIV Combo POCT detected all P24 antigen at levels >30 pg/ml.
Discussion/conclusion The Alere™ HIV Combo POCT has 89% sensitivity for p24 antigen at 20 min and 93% at 40 min. These preliminary results suggest that the new Alere™ HIV Combo POCT may be able to detect early infection adequately.

P96 ACCESS OF LEVEL 2 SEXUAL HEALTH SERVICES BY MEN WHO HAVE SEX WITH MEN: WHO GOES AND WHAT SERVICES DO THEY GET?

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10.1136/sextrans-2015-052126.139

Background Men who have sex with men (MSM) bear a disproportionate burden of sexually transmitted infections (STIs) including HIV. While routine STI surveillance data indicate MSM regularly access genitourinary medicine (GUM) services for their sexual health care, the extent to which MSM attend non-specialist Level 2 sexual health services is unclear. We investigated access of Level 2 services by MSM in England.
Methods We used provisional data from the GUM Clinic Activity Dataset (GUMCADv2) to compare the characteristics, service usage and outcomes between MSM accessing GUM and Level 2 services who reported data in 2013.
Results Of all male attendances where sexual orientation was recorded, 12.3% (6,957/57,048) of Level 2 attendances were among MSM compared to 26.3% (299,456/1,139,424) of GUM attendances ($p < 0.001$). MSM attending Level 2 compared to

GUM services, were younger (mean age: 30.5 yrs vs 38.5 yrs; p < 0.001), and more likely to be of black ethnicity (6.8% vs 4.1%; p < 0.001) and reside in London (49.9% vs 46.0%; p < 0.001). MSM attending non-GUM services were more likely to have a full sexual health screen (41.4% vs 27.0%; p < 0.001), HIV test (8.9% vs 7.1%; p < 0.001), and be diagnosed with chlamydia (6.2% vs 3.0%; p < 0.001), gonorrhoea (5.6% vs 4.6%: p < 0.001) and first-episode genital warts (1.5% vs 1.0%: p < 0.001). There was no significant difference in the proportion newly diagnosed with HIV (0.57% vs 0.69%; p = 0.268) or first-episode genital herpes (0.47% vs 0.46%; p = 0.830).

Conclusion Level 2 sexual health services play an important role in the sexual health care of MSM, especially those of younger age.

P97 MISSED OPPORTUNITIES FOR DIAGNOSING HIV IN A DISTRICT GENERAL HOSPITAL IN AN AREA OF HIGH HIV PREVALENCE

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Background Delayed diagnosis of HIV is associated with significantly increased morbidity and mortality. Our clinic has a high rate of advanced HIV at diagnosis (61% presenting with a CD4 <350) indicating that there may be missed opportunities for earlier testing.

Aim To review all recent new diagnoses of HIV for potential missed testing opportunities.

Methods Retrospective review of clinic, hospital and emergency department records for all new patients referred to the HIV clinic between January 2014 and January 2015. Previous hospital admissions, outpatient and emergency department attendances and GP visits were reviewed for the year up to diagnosis. Where a patient was admitted to hospital, time to diagnosis, outcome and inpatient stay was recorded.

Results 70 new patients: 24 transfers of care (excluded); 46 new diagnoses.

Gender: female	18/46 (39%)	CD4 Count	29/46 (63%) CD4 <350 11/46 (24%) CD4 <100 Mean CD4 Count 322
Sexuality: MSM	17/46 (37%)	Referral Route	SRH 13/46 (28%) Inpatient 10/46 (22%) GP 10/46 (22%) Other 13/46 (28%)
Country of birth			
UK	12/45 (27%)		
Sub-Saharan Africa	23/45 (51%)		
Other	10/45 (22%)		

24/46 (52%) were seen at least once at the hospital or by the GP in the 12 months prior to their diagnosis. 14 admissions to hospital at the time of diagnosis: mean length of stay 14 days (range 2–47).

Discussion There are significant opportunities for earlier HIV testing in our hospital and local GP practices. We are using this data as part of a business case to roll out HIV testing for all acute medical admissions.

P98 HIV TESTING IN SOUTH LONDON

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10.1136/sextrans-2015-052126.141

Background Early diagnosis is an important factor associated with HIV-related mortality, morbidity and onward transmission. The local prevalence is estimated at 7.8 per 1000 population and 61% of patients are diagnosed with a CD4 count of <350. Despite the National HIV testing guidelines being published in 2008, local HIV testing remains low due to lack of resources, funding and clinical awareness.

Objective To pilot routine HIV testing of all medical admissions during National HIV testing week.

Methods General medical admissions during 22nd–30th November 2014 were offered a third generation *INSTI* HIV point of care test (POCT) the morning after admission. A&E attendees between 9 am and 4 pm on 1st December 2014 (World AIDS day) were also offered POCTs. Basic demographics were collected and analysed with appropriate statistical tests.

Results 141 POCTs were offered in medical admissions; all 126 individuals who accepted (89%) tested negative (64 white British (51%), 10 black African (8%)). 14 refused testing; 9 tested before. 21 individuals were not offered POCTs due to unavailability/ inappropriateness. There was no statistical difference in mean ages or proportion of females/males that accepted or refused testing in this group. 32 patients tested in A&E were all negative (11 black African (34%)).

Abstract P98 Table 1 HIV testing in South London

Category	Medical	A&E	Two tailed P values *t-test, **Z-ratio
Age	56.9 (n = 126)	41.6 (n = 32)	*P < 0.0001
Ethnicity			
Black African	n = 1	n = 11	**P < 0.0002
White British	n = 64	n = 8	**P < 0.0089

Discussion There was a high uptake of HIV testing amongst general medical admissions indicating routine testing is very acceptable to patients. Moreover, a younger population group presents in A&E compared to admissions; a significant proportion being Black African origin. This may be an appropriate target group to consider for testing.

P99 RENAL AND BONE SAFETY OF TENOFOVIR ALAFENAMIDE VS TENOFOVIR DISOPROXIL FUMARATE

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Background Off-target renal and bone side effects may occur with tenofovir disoproxil fumarate (TDF) use. Compared with TDF, tenofovir alafenamide (TAF) results in significantly reduced plasma tenofovir (TFV) and may have less renal and bone toxicity.