

P13

**NEW HIV DIAGNOSES IN A BUSY INNER-CITY COHORT: HOW FAR HAVE WE COME?**

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P14

**PATHWAYS TO HIV DIAGNOSIS AND TREATMENT AMONG MIGRANTS AND THEIR PARTNERS IN INDIA**

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P15

**ARE WE FOLLOWING BHIVA GUIDELINES IN NEWLY DIAGNOSED HIV PATIENTS?**

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P16

**WHAT WERE THE REASONS FOR LOW CD4 COUNTS IN PATIENTS STARTING ANTIRETROVIRAL (ARV) MEDICATION?**

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17–62). Ethnicity data showed only 37.7% were white with the majority being Black (54.4%). 6 (7.0%) of 85 patients had a major NNRTI resistance mutation. Mean nadir CD4 count was 222 (range 5–610). 101 (88.6%) patients had a CD4 count under 350. 106 reasons for low CD4 count were recorded. 65 patients (64.3%) had low CD4 counts because of late diagnosis, 15 (14.8%) had declined ARV when initially offered while 10 (9.9%) had been lost to follow-up. The patients starting Rx within 1 year of diagnosis (no=67) had a lower mean nadir CD4 count compared to those diagnosed earlier (no=47) (162 cells vs 271 cells,  $p<0.5$ ). There was no difference between the two groups in the number of patients having a pre-treatment resistance test, the mean CD4 rise 6 months after treatment initiation and the proportion of patients having an undetectable viral load 12 months after treatment initiation. At 6 months the mean CD4 count had risen from 222 at treatment initiation to 360, but 54 (47.4%) still had a CD4 count under 350. The main reasons for this were poor immune recovery in 80.7%, poor adherence 7%, poor attendance 5.3%.

**Discussion** A proportion of our cohort started ARVs with a low CD4 count mainly due to late diagnosis. This is an important barrier to ARV initiation and needs to be addressed and our audit data would support the need for extra support and resources directed to earlier HIV diagnosis.

**P17** **FOUR YEARS OF POST EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE (PEPSE) PRESCRIBING AFTER SEXUAL ASSAULT IN A SEXUAL ASSAULT REFERRAL CENTRE (SARC)**

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**Aim** We have reviewed 4 years of PEPSE use in our SARC and its follow-up and compared with BASHH guidance on PEPSE after sexual assault.

**Methods** Retrospective review of SARC and GUM notes from 12 October 2007 to 12 October 2011

**Results** 1233 cases seen 127 given PEPSE, for two notes not available Age range 14–55 years mean 27. 81% were female. 51% were vulnerable. Ethnicity of assailants, 81 White European, 20 African, 5 Asian, 4 Dark European, 13 unknown. One man had PEPSE twice. Mean time till received PEPSE was 25 h range 3–168 h, 5 over 72 h. Using BASHH guidelines PEPSE was recommended in 22%, considered in 50% and 26% was not recommended as either >72 h or low risk exposures. 87 returned at day 3 for review. 29 stopped PEPSE early. One was HIV positive at baseline, 12 due to side-effects, three felt the assault was low risk of HIV at review, 13 for other reasons. 27% returned for HIV test at 3 months, 14% at 6 months. No sero-conversions seen. 17% completed PEPSE. 43 given PEPSE while on interacting drugs. Eight were identified and given appropriate management. Most common interaction was hormonal contraception.

**Discussion** Completion rates for PEPSE were low and similar low rates have been seen in alike studies. No long-term side effects were seen but only 19% of interactions were identified. PEPSE is a risk reduction method and so clients should not be put at risk of serious drug interactions. 33 were given PEPSE for low risk exposures which is “not recommended” by BASHH. 10 of these accepted full PEPSE course. The decision to start PEPSE is often made under stressful conditions so GUM now review need for PEPSE after completing the starter pack. It is vital staff starting PEPSE prescribe within the guidelines and they and GUM staff consider interactions. We have created a proforma which reminds staff only to give within 72 h and review interactions. It also outlines HIV

risks after exposure and hopefully make it easier to discuss this with the client.

**P18** **POST EXPOSURE PROPHYLAXIS FOLLOWING POSSIBLE EXPOSURE TO HIV INFECTION: AN EVALUATION OF 391 ATTENDANCES AT THREE CENTRAL LONDON SEXUAL HEALTH CLINICS**

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**Background** Providing post exposure prophylaxis (PEP) following possible HIV exposure is a common GU presentation. However, few studies have evaluated this practice.

**Aim(s)/Objective(s)** To answer the following on PEP presentations: age, sex, nature of exposure to HIV, time to presentation for PEP, side effects, completion rates, presence of sexually transmitted infections (STIs), appropriateness of PEP dispensing and comparisons of findings with other published studies.

**Methods** GUM clinic attendances were evaluated from April 2009 to March 2010.

**Results** There were 391 PEP attendances: 373 males (96% MSM), 18 females. Age range 19–57 (mean 35.4) years. Presentation followed anal sex in 89%, vaginal sex in 5%. The remainder attended following oral sex, splash incidents, injecting drug use, or other exposure. Forty six percent attended within 24 h, in one instance PEP was dispensed beyond 72 h. The majority completed PEP (82%). GI side effects were experienced by 60%. Baseline screening for hepatitis B showed active infection in 1% and immunity in 74%. A baseline HIV test was conducted in all but one patient. An STI screen was conducted at or around day 14 in 69% of patients, with 12% testing positive for an STI in line with previously published data. Follow-up rate at 3–6 months was 52%: Of 203 patients tested for HIV at follow-up, 2 (1%) tested positive.

**Conclusions** PEP was dispensed appropriately in the majority of cases. The fact that 82% of individuals completed treatment despite side effects is likely to be due to the use of more tolerable regimens than were used historically. The presence of an STI in 12% of people tested highlights the importance of screening in individuals presenting for PEP. The fact that only 52% of patients attended for a follow-up HIV test at 3–6 months is of concern and warrants further exploration.

**P19** **WHAT'S UP? ERECTILE DYSFUNCTION (ED) IN HIV POSITIVE MEN**

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**Background** Antiretroviral therapy in HIV positive patients has resulted in improvements in survival, quality of life and fulfilling sexual relationships. Treatment using phosphodiesterase type 5 inhibitors (PDE5i) for ED has simplified management. However nitrates, including “poppers”, and protease inhibitors (PIs) can interact with PDE5i leading to hypotension and high levels of PDE5i. Ethical issues are a consideration as treatments can lead to HIV transmission if safer sex is not practised. We reviewed our HIV positive men with ED and their outcomes after treatment.

**Methods** 94 HIV positive patients attending our ED clinics from 2006 to 2012 were identified. Data were collected by review of notes and databases. Patients on PIs were started on half of the lowest