

1150 resources have been uploaded to the site which, have been downloaded over 40 000 times, an average of 35 downloads per resource. Topics related to internet use and online interventions are particularly popular, followed by clinical slide sets, and podcasts.

**Conclusion** During the 4 years of its existence, STDPO has demonstrated to meet a need in the STD/STI professional community for an interactive, two-way, clearing house of STD/STI-related information.

# P163 PATIENT CHOICE: IS THE LOCAL HIV SERVICE PREFERRED?

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**Aim** To investigate the distance travelled by patient to a specialist HIV clinic in the Home Counties.

**Methods** Retrospective review of the electronic database of HIV patients attending the clinic from January 2011 to January 2012. Data on gender, ethnicity, sexual orientation, age and residential postcode was collected. The distance to our service was compared to that of the nearest available specialist clinic HIV clinic for each patient. Demographic data were also collected.  $\chi^2$  Tests were performed to compare categorical data.

**Results** 220 patients attended. The median age was 41 years, range 15–74. Our clinic was the closest HIV service for 89 (40%) patients. Of the 131 who selected our service in preference to their local service, 50% travelled up to 10 miles, 15% 11–20 miles, 14% 21–30 miles and 21% more than 30 miles. Interestingly the nearest service for 13 (10%) of these patients was an inner city teaching hospital. There was no significant difference in age, gender or sexual orientation between those who lived locally or travelled further, except for ethnicity. 66% of White British men and women were prepared to travel further for their HIV care compared to 51% for other ethnic groups ( $p=0.02$ ) (see abstract P163 table 1).

**Conclusions** More than half our HIV patient cohort elected to travel further rather than utilise their local HIV services. The reason for this choice is unclear. However this study highlights the importance of considering patient choice when commissioning, planning and providing HIV services. Further research exploring the reasons for patient preference may aid our understanding of the aspects of HIV care that are particularly valued by our patients.

Abstract P163 Table 1 Demographics of HIV cohort

	Men (n = 141)	Women (n = 79)
Sexual orientation (%)		
Heterosexual	64 (46)	79 (100)
Bisexual	6 (4)	
Homosexual	71 (50)	
Ethnicity (%)		
White British	108 (77)	16 (23)
Black African	24 (17)	58 (73)
Other	9 (6)	5 (4)

# P164 WHICH ASPECTS OF STIGMA ARE MOST IMPORTANT IN AN INTEGRATED SEXUAL HEALTH SERVICE?

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**Background** The stigma of sexual health services is pervasive and affects all user groups. It is likely to affect access to and satisfaction

with the service. Reducing stigma has to be an essential aspect of improving sexual healthcare. Stigma has four domains: disclosure concerns, negative self-image, public attitudes and positive (non-stigmatising) aspects. It is currently not known which of these domains is perceived as most relevant by service users.

**Objective** To determine which aspect of stigma of the service was felt most intensely by service users in a level 3 integrated sexual health service (ISHS).

**Method** Application of a validated 15 item quantitative tool to assess stigma among 200 unselected patients attending an ISHS in outer London.

**Results** A total of 77 strong agreement with a statement describing stigma of the service were recorded. Of them nearly half were given in response to two statements: statement (S) 5: "I am careful whom I tell that I have been in this clinic" (14) and S 10 "I am concerned that I bump into someone I know when I am at this clinic" (16). No other statement attracted >6 positive strong responses. Of the 171 responses indicating a moderate stigma of the service 24 were given to the S1 "I won't tell anyone that I came to this clinic because I am concerned about their reaction". Statement 5 and S10 received 22 moderate agreements each while S6 "I worry that people who know that I have been here tell others that I have been to this clinic" attracted 17 moderate positive responses.

**Discussion** Our research indicates that disclosure concerns are the key source of stigma for the ISHS. Other aspects like self-image or public attitudes were less relevant. The high level of concerns expressed in S10 throws a new light on the issue of time spent in the waiting room. It suggests that waiting can be very stressful as stigmatising encounters are anticipated.

# P165 GUM/HIV TRAINEES' EXPERIENCE AND TRAINING NEEDS IN THE MANAGEMENT OF PATIENTS DISCLOSING SEXUAL VIOLENCE

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**Background** Patients attending GUM clinics may disclose sexual violence. Are GUM/HIV trainees equipped to manage these cases?

**Aim** To assess the experience and training needs of GUM/HIV trainees in managing patients disclosing sexual violence (SV patients).

**Method** An e-survey was open to GUM/HIV trainees for 12 weeks from February 2011. Data were analysed in Excel.

**Results** Of the 158 current GUM/HIV trainees, 44 (28%) completed surveys. All respondents managed SV patients and 59% managed  $\geq 1$  SV case/month. Of these, 98% had seen females, 66% males, 73% 16–17 years/olds, 34% 13–15 years/olds, 5% under-13s. All respondents routinely asking about SV saw  $\geq 1$  case/month vs 50% of those who rarely/never asked. Confidence increased with frequency of seeing patients: 96% (25/26) seeing  $\geq 1$  SV patient/month felt confident vs 67% (12/18) seeing <1/month. Confidence in managing female, male and under-18 SV patients was reported in 86%, 79% and 58% respectively. In the six units with a dedicated SV clinic two trainees had worked in one, overall, 92% would have liked to. Similarly, 14% had worked in a Sexual Assault Referral Centre, 81% would have liked to. Respondents had trained in safeguarding children, adult SV, chain of evidence, vulnerable adults and domestic violence in 92%, 82%, 76%, 64%, 32% respectively. Abstract P165

Table 1 details respondents' reported competencies and training availability in 2010 curriculum skills.

Abstract P165 Table 1

	Competent (%)	Not competent, training available (%)	Not competent, training not available (%)
Emergency contraception counselling	100	0	0
Referring to support organisations	90	10	0
Prescribing STI/HIV/Hep B prophylaxis	90	10	0
SV history taking and risk assessment in u-18s	89	4	7
Forensic exam counselling/documenting injuries	64	29	7
Documenting history/exam for medico-legal report	46	19	35

**Conclusions** Wide variation exists in reported SV experience, training received and training availability, in the 28% of trainees responding. Regular accessible training is needed in identifying and managing patients disclosing SV.

# P166 INCREASING SCREENING FREQUENCY IN MEN WHO HAVE SEX WITH MEN (MSM): IMPACT OF EXPLICIT GUIDANCE ON RISK PROFILING ON UK SERVICE

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**Background** STI and HIV diagnoses are increasing among MSM. Mathematical modelling shows increasing screening frequency can reduce STI prevalence, especially targeting MSM engaging in risk behaviours. International guidelines from both the CDC and Australasian Society for HIV Medicine clearly define risk behaviours with adapted screening intervals—contrary to the UK where NICE guidance is vague.

**Objectives** To investigate impact of applying stricter international screening guidelines for MSM, on service workload and earlier STI diagnosis in a UK level 3 service [L-3S].

**Methods** A validated risk questionnaire distributed to MSM attending a large provincial L-3S over a 3-month period explored their actual screening frequency, STI diagnoses and risk behaviours in the prior 12 months. Australian screening guidelines were applied to the data to identify MSM needing more frequent screening. Projections to the larger MSM population attending over 12 months were modelled, based on the demographics of the respondents.

**Results** 126/357 completed the questionnaire, 89 were identifiable. There was no statistically significant difference between STI rates ( $p=0.18$ ) and HIV diagnoses ( $p=0.62$ ) between identifiable questionnaire respondents and other MSM clinic attendees. Demographic analysis showed the sample group was representative of the larger cohort. In 2011, applying Australasian Society for HIV Medicine risk profiling for the 793 MSM who attended the unit, 26% would require one additional 6-monthly attendance for HIV screening, while 6% would require two visits. Additional STI screening visits would be needed by 25% (1 visit) and 10% (2 visits). 29% of STI diagnoses were in infrequent attendees.

**Conclusions** Stricter UK screening guidelines for MSM defining and weighting risk behaviours explicitly in line with other international guidelines, would increase L-3S MSM visits by 30% and potentially diagnose a large proportion of disease earlier. In light of the results UK guidelines may benefit from review.

# P167 MANAGEMENT CHALLENGES OF A TRIFECTA (HIV, HEPATITIS C AND SYPHILIS TRI-INFECTION) AND AN UPDATE ON HIV/HCV CO-INFECTION

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This complex case is of an ageing HIV positive patient, who had been a management challenge to a multidisciplinary team over the past decade in Adelaide, South Australia. He had various comorbidities and had developed various other infections, mostly sexually acquired, complicating his management. The patient was diagnosed as HIV positive in 1985 and commenced on HAART in 1989. He relocated to Adelaide in 2002. His major issues at that time were sexual dysfunction and bipolar affective disorder. On routine screening mid 2005, his CD4 count had dropped. Liver function tests were abnormal with raised GGT, ALT and AST. Subsequently, he was found to be Hepatitis C positive (Genotype 3). He adamantly denied intravenous drug use but had unprotected anal intercourse with other men. He also had a Prince Albert ring inserted. The hepatitis C infection was apparently acquired sexually. He proceeded to have multiple sexual partners interstate and overseas. On return to Adelaide at the end of 2005, he was found to be syphilis EIA positive, RPR 1:32 and FTA IgG positive. He was treated with benzathine penicillin. Management of his hepatitis C initially involved changes to his HAART over the next 2 years before he finally decided to commence interferon and ribavirin therapy for his Hepatitis C co-infection. He was on treatment for 6 months, with close monitoring by the team psychiatrist in view of his psychiatric comorbidities. To date, he has maintained sustained virological response. An overview of HIV/Hepatitis C co-infection from recent literature review will also be presented.

## Clinical case reports

# P168 ACUTE GENERALISED EXANTHEMATOUS PUSTULOSIS INDUCED BY PNEUMOCYSTIS CARINII PNEUMONIA (PCP) PROPHYLAXIS WITH DAPSONE

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**Background** Acute generalised exanthematous pustulosis (AGEP) is a severe cutaneous adverse reaction. Most cases are drug related, however the condition has been associated with viral infections.

**Objective** AGEP in the setting of HIV is uncommon. We report a case of AGEP induced by PCP prophylaxis with dapsone.

**Results** A 34-year-old HIV-infected Nigerian woman was admitted to hospital with a 2-week history of a progressing pustular skin rash. CD4 count 1 month prior to admission was 176 cells/mm<sup>3</sup> and she had not been taking antiretrovirals since 2008. Three weeks prior to presentation she had commenced Dapsone for PCP prophylaxis. Admission to hospital revealed a fever of 40°C, tachycardia, hypotension and a widespread erythematous papular eruption with overlying pustules. Laboratory investigations revealed; haemoglobin 7.6 g/dl, raised eosinophils of 0.67×10<sup>9</sup>/l, C reactive protein 144 mg/l and Direct Coombs test was positive. A venous methaemoglobin level was raised at 3.5% and chest radiography revealed subtle consolidation at the left base. Broad spectrum antibiotics and fluids were initiated and Dapsone was withdrawn. Dermatology review raised the clinical suspicion of drug rash with eosinophilia and systemic symptoms (DRESS) or AGEP. Skin biopsy supported the clinical diagnosis of AGEP. She remained systemically unwell