

6 months, 78 (64%) reported being sexually active. 14 (12%) reported at least 1 new partner in the last year. 52 (35%) were offered STI screening in the last year and 32 accepted (62%). 9 (28%) were diagnosed with STI(s): Gonorrhoea, chlamydia, warts, LGV, syphilis and hepatitis C. Those reporting partner change were more likely to be diagnosed with STI(s) (58% of those screened vs 10% not reporting partner change, $p = 0.002$).

Discussion/conclusion A high prevalence of STIs was observed. Sexual history taking is essential to identify those most at risk. However, STIs were diagnosed in those reporting no partner change, supporting routine STI screening among our cohort.

P77 UNDIAGNOSED HIV: CAN AT RISK GROUPS BE IDENTIFIED FOR A NEW TESTING STRATEGY?

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Background/introduction Public Health England report (Nov 2014) the number of HIV tests is increasing, number of positive diagnoses decreasing, but proportion undiagnosed HIV unchanged. We aimed to suggest new local strategy. Demographically identifying late diagnoses ($CD4 < 350$ cells/mm³) would find groups within the population more likely to be diagnosed late. Testing that group could uncover undiagnosed early HIV.

Methods Data gathered about HIV diagnosed in our city Jan 2009–Dec 2014: age, gender, ethnicity, orientation, previous test, indication, place tested. Chi-Square compared early/late diagnoses. Under-served compared to well-served demographics.

Results 251 new diagnoses in 5 years. 125 early, 126 late. Disproportionate late diagnoses:

- females ($p = 0.023$) without previous test ($p = 0.006$)
- HSM (heterosexual males) ($p = 0.068$) without previous test ($p = 0.004$)

No significant difference between early/late diagnosis:

- ethnicity: Caucasian, sub-Saharan African, other ($p = 0.103$)
- age: <50 vs >50 ($p = 0.74$)
- bisexual males ($p = 0.87$)

Disproportionate early diagnoses:

- MSM males ($p = 0.032$) with previous test ($p = 0.052$)

Abstract P77 Table 1 HIV testing

	Females	HSM no prev test	MSM
Total	48	37	119
Median age	34 (20–64)	43 (22–76)	35 (17–66)
Median CD4	221 (8–941)	177 (2–718)	419 (8–1003)
Indications	Antenatal testing 8/48	Partner positive 7/37	SH screen asymptomatic 34/119
	Partner positive 7/48	Respiratory illness 7/37	SH screen symptomatic 17/119
			Partner positive 17/119
Place	GUM 13/48	Secondary care	GUM 59/119
	GP 10/48	15/37	GP 19/119
	Secondary care 10/48	GP 9/37	GUM outreach 14/119

Discussion/conclusion Barriers to earlier self-presentation of females and HSM should be examined. MSM benefit from specialised clinics yet are $<50\%$ diagnoses. Likely public and clinician unawareness of risk excludes earlier testing.

P78 IS ROUTINE HIV TESTING BY NURSING STAFF ADMITTING PATIENTS TO HOSPITAL FEASIBLE?

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Background/introduction Routine HIV testing in acute medical admissions is recommended in areas of high HIV prevalence. A local sero-anonymous prevalence study suggested high rates of undiagnosed HIV in both medical and surgical admissions. We have developed a successful non-clinician based model of HIV testing using a dedicated Health Care Assistant (HCA) in medical admissions. We are keen to move back to clinician-based HIV testing using the HCA as a testing-facilitator offering education and a bespoke HIV testing training resource to support HIV testing. This model will allow roll-out of HIV testing to all admissions.

Methods A service evaluation through purposive sampling to assess whether nursing staff would be willing to perform routine HIV testing and to pilot the HIV testing training resource.

Results 10 nurses from the Emergency Department, Acute Medical Unit, and medical wards responded. 4/10 felt that current coverage (a single HCA) was inadequate. 8/10 said they would be willing to routinely test admissions for HIV provided support and training from the HIV Screening HCA was given, especially around the informed consent process. 1/10 suggested that routine screening would make discussing HIV testing less awkward. 8/10 felt the training resource was comprehensive and helpful.

Discussion/conclusion This pilot suggests that Routine HIV testing by nursing staff admitting patients is feasible with the support of an HIV testing facilitator and an HIV testing training resource.

P79 HIV MONITORING AND INVESTIGATIONS, AN AUDIT SERIES: USE OF VISIT THEMED PROFORMAS TO IMPROVE CARE

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Background Recommended HIV routine monitoring and investigations in the outpatient setting has become increasingly extensive. HIV clinics use different methods including proformas to record consultation visits. Due to time constraints, in a busy clinic, the recommended monitoring and investigations can be overlooked.

Aim To raise standards of monitoring and investigation of HIV attendees by reviewing our clinical proformas.

Method Three annual retrospective case notes review of 50 to 53 patients with HIV attending service for HIV related care. Standards were set based on national BHIVA standards. In 2011 an annual proforma was introduced, which was updated in 2012 to meet the BHIVA 2011 monitoring guidance. However, the annual visit was then long and time constraining, so in 2013

monitoring across three themed visits every 4 months was created using three new proformas.

Results In 2011 smoking history, vaccinations, alcohol use, STI screening and mental health issues were poorly documented failing to meet standards. There was an overall improvement in those areas in 2012 with the updated proforma and continued improvement when three themed visits were created (smoking 37% to 96%, alcohol use 35% to 88%, and Influenza vaccine recommendation 63% to 94%). Areas with initial higher results such as cardiovascular risk and urinalysis achieved even higher outcomes (80% to 100%, 92% to 96% respectively).

Discussion Updating proformas to produce three themed reviews each year increased standards further in most areas and has had a positive effect on the HIV clinic with staff stating it feels less rushed, feels more focused and easier to keep to time.

P80 WOULD YOU LIKE A HIV TEST?

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Background Opt out HIV testing has been a policy in our sexual health clinic for over 10 years. In 2010, in the UK, 78% of those attending a sexual health clinic were offered a HIV test, in our clinic among women was 69%.

Aim To evaluate and describe the patients who did not have a HIV whilst attending our sexual health clinic.

Method A retrospective case note review of women who did not have a HIV test between 1/1/14 to 31/3/14.

Results 197 females were identified (age range 13–63 years, with a mean, median and mode of 38, 20 and 18 years). Ethnic distribution was 69% White, 12% Black, 9% Asian, and 10% other ethnic backgrounds. 131 (66%) attended for a STI screen, 28 for contraception, 35 for both, and 4 with other problems. 33 patients refused to have a HIV test; however 150 (76%) cases had no documented reason for not performing a HIV test. Other reasons documented include: negative HIV test in past 4 months (2%), incubation period discussed/patient to return (2%), needle phobia (1%), no sexual contact (1%) and failed phlebotomy (0.5%). 182 (92%) had a NAAT test for chlamydia and gonorrhoea. There were 15 identified cases of chlamydia, 2 with chlamydia and gonorrhoea, and 1 case of gonorrhoea.

Conclusion Only 47 (23%) patients had a documented reason for refusal of HIV testing, however more commonly no reason was documented. We plan to present these findings to our department for discussion aiming to improve opportunistic HIV testing.

P81 AUDIT OF HIV TESTING IN A LYMPHOMA CLINIC

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10.1136/sextrans-2015-052126.124

Background/introduction Non-hodgkins lymphoma (NHL) is the second most common malignancy in those with HIV, and AIDS related lymphomas (ARL) have increased as a percentage of first AIDS defining illness (ADI). Hodgkins lymphoma (HL) is a non AIDS defining malignancy but has 10 to 20 times higher incidence in those who are HIV positive. To assist in reducing late diagnosis of HIV, BHIVA guidelines in 2014 highlighted

diseases where an HIV test should be offered including NHL and HL.

Aim(s)/objectives To establish whether patients newly diagnosed with NHL or HL in a large district general hospital lymphoma clinic were being tested for HIV in accordance with national and local guidelines.

Methods Patients newly diagnosed with NHL or HL from January 2013–January 2015 were identified via positive histology results recorded by the laboratory. Identification of HIV testing was via electronic blood results records.

Results

Abstract P81 Table 1 HIV testing in lymphoma

Year	Number of new lymphoma diagnoses	Number tested for HIV	Number positive HIV results
2013	61	12	0
2014	55	39	0
2015 (Jan)	1	1	0

Discussion/conclusion Local haematology guidelines from 2014 indicate HIV and HCV/HBV testing for patients prior to Rituximab chemotherapy for lymphoma. The results indicate that since implementing guidelines, more HIV testing occurred, but without an increasing identification of undiagnosed HIV. A 2003 study investigating HIV positivity in newly diagnosed NHL identified HIV positive patients had more aggressive lymphoma histology and increased B symptoms. Continued testing for HIV in lymphoma, especially if presenting with B symptoms, is recommended.

P82 FACTORS ASSOCIATED WITH DELAYED DIAGNOSIS IN HIV LATE PRESENTERS

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Background/introduction Despite presenting indicator conditions, HIV diagnoses are often delayed resulting in higher mortality and morbidity.

Aim(s)/objectives To review the rate of late HIV diagnosis locally and identify factors associated with delayed diagnosis.

Methods Retrospective GUM and hospital case note review of all 31 newly diagnosed HIV patients attending the Norwich GUM clinic in 2013.

Results 12/31 (38%) were late presenters with CD4 count persistently below 350 cells/mm³. At diagnosis 3/12 had no symptoms or indicator conditions; 2/12 had symptoms that were immediately acted upon; 7/12 had indicators illnesses not acted upon in a timely fashion hence the diagnoses were delayed from between 2 months to 2 years. Of these 7 delayed diagnoses 2 presented to GUM and declined testing initially although they were men who had sex with men (MSM). 5/7 presented as acute admissions; 3 were MSM (2 bisexual), 1 heterosexual male and 1 female. All of the 5 patients presenting with acute admission had medical associations; one was a nurse, 4 had immediate family members or a partner who was a nurse, doctor or pharmacist. The mean age of the male patients who were diagnosed in hospital was 65 years (range 52–80 years).

Discussion/conclusion HIV testing may be less likely to be undertaken for older inpatients and those with medical associations.