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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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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10.1136/sextrans-2015-052126.125

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/mm^3. 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.