Background/introduction Southern Africa has some of the highest rates of HIV with a prevalence of over 10% in the adult population. As we enter the second decade of the epidemic over 17.1 million people in southern and eastern Africa live with the disease. In Zambia around 100,000 children under the age of 14 and in Malawi an estimated 170, 000 children have HIV.
Aim(s)/objectives Case study of 2 paediatric patients in Southern Africa with diagnosis of HIV related complications.
Methods Individual cases were examined and followed up.
Results An 8 year old girl, is seen in rural Zambia with new diagnosis of HIV, moderate malnutrition, septic wounds and cough. She lives far from a rural hospital and during wet season is unable to cross the river to attend follow up. A 14 year old boy in rural Malawi is seen with severe malnutrition, HIV treatment failure after late diagnosis, chronic abdominal pain due to 3TC pancreatitis and new neurology. The family refuse to attend the palliative care team at central hospital.
Discussion/conclusion Zambia currently has an estimated ART coverage of 72%. Whilst this seems like excellent progress the child vs adult breakdown shows that only 26% of children with HIV have access to treatment compared to 84% of adults. In Malawi 51% of adults with HIV are on ART but only 30% of children receive therapy and 30% of paediatric cases receive a diagnosis of HIV within first 2 months of life. These cases explore the inequalities that children face with late diagnosis of HIV.

P042 MSM SCREENING IN SAUNAS – IS IT WORTH IT?

Lee Portas*, Adrian Langham, Ruth Taylor. *Nottingham University Hospitals NHS Trust, Nottingham, UK*

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Background Commissioners requested STI screening for MSMs attending male-only saunas in an effort to reduce HIV late diagnosis and engage hard-to-reach clients. Similar schemes have been successfully described elsewhere.
Aim Examine success of sexual health screening (SHS) and health promotion for 'high risk' MSM in saunas. We examined infection rate and proportion of individuals who were not accessing services elsewhere.
Methods Two saunas were visited monthly over 16 months by senior nursing staff. All attendees were offered a full SHS (HIV, STS, Hep B, GC, CT) and safer sex advice. Symptomatic individuals were signposted to main GUM clinic. We collected demographics and data on previous clinic attendance.
Results Results are outlined in Table 1. One symptomatic patient was signposted to the GUM clinic. Health promotion was provided to all.

Abstract P042 Table 1 MAM screening in saunas

Total Screened	Age range (yrs)	Accessed mainstream services	Sexuality	HIV/STS testing	Positive results	
30	22–76 (mean 50)	19 (63%)	26 Gay (87%) 4 Bisexual (13%)	26 (87%)	Chlamydia	0
					Gonorrhoea	3 (10%)
					HIV	0
					Syphilis	0

Discussion 64 hours of staff time were used (total cost £2,632 – not including lab costs). Small numbers were seen, with an overall 10% positivity rate for STIs and no new HIV diagnoses. Many regular attendees declined repeat screening as they perceived themselves to be at low risk. We concluded that supplying condoms/lubrication and prominently displaying health promotion literature was a more effective way of engaging with this group in terms of both time & cost.

P043 FLOW CYTOMETRIC CELL COUNTS: NOT PERFECT? (HOW GETTING A CALCULATOR OUT CAN SUGGEST AN ANOMALOUS RESULT)

[1]Rebecca Thomson-Glover*, [1]Colm O'Mahony, [2]James Darroch. *[1]Countess of Chester NHS Foundation Trust, Chester, UK; [2]Royal Liverpool University Hospital NHS Trust, Liverpool, UK*

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Background/introduction HIV patients have their CD4 counts measured regularly using flow cytometry, 'single platform' measurement being the current standard. Recently, two HIV patients attending for routine follow up blood tests showed unexpectedly low CD4 counts compared to previous results. Using the patients' total lymphocyte counts (obtained from contemporaneous testing on a haematology analyser) and CD4% (from the flow cytometry report), we calculated a more expected result. This prompted a review of our CD4 counts comparing single and dual platform results.
Aim(s)/objectives To identify any anomalous results when comparing flow to calculated CD4s.
Methods Fifty-nine CD4 counts from 38 HIV patients (27 males and 11 females) attending clinic for routine bloods from 18/01/2015 to 09/02/2016 were reviewed.
Results The table shows the comparison between the dual platform CD4 and the single platform CD4. The two patients that triggered the query are in green (male) and red (female). The sequential before/after CD4 counts for the male patient (pale green) and the female patient (pale pink) are also highlighted on the table.
Discussion/conclusion Reassuringly, statistical analysis showed very close correlation between the two methods, apart from the two odd results. Previous and subsequent counts in these two patients were normal, as expected. Twenty years ago only the percentage was available so absolute number was calculated using the simple method: lymphocyte count × CD4%. As usual in medicine, no methodology is perfect. Unexpected results should be questioned and, if necessary, repeated, especially if important therapeutic decisions depend on them.

P044 PEP/PEPSE REAUDIT - WHOSE NOTES ARE THEY ANYWAY? – THE DATA PROTECTION ACT RESTRICTING CLINICAL AUDIT

Rebecca Thomson-Glover*, John Evans-Jones. *Countess of Chester NHS Foundation Trust/East Cheshire NHS Trust, Chester, UK*

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Background/introduction Post Exposure Prophylaxis (PEP) is prescribed to patients presenting with a history of occupational or sexual exposure to HIV infection. The British Association for Sexual Health and HIV (BASHH) published new clinical guidelines on PEP following Sexual Exposure (PEPSE) in 2015.

Aim(s)/objectives To audit occupational PEP/PEPSE related attendances in a sexual health clinic (SHC) in 2015 and compare to a previous audit (2011–2013).
Methods A retrospective case note review of patients attending in 2015 for PEP/PEPSE. Clinical records were unavailable for patients attending prior to April 2015 due to the SHC contract transferring to a new provider.
Results A total of 8 patients attended for PEPSE, two were initiated in A&E, 1 in a Sexual Assault Referral Centre (SARC) and 4 in the SHC. All patients attended after sexual exposure, with none attending after needle stick injury. All patients were started on PEPSE within 72 hours, had baseline HIV test and STI screen. All had PEPSE prescribed within the recommended indications compared to 88% previously. Fifty percent finished PEP course whilst 25% had a documented HIV test 4–6 weeks post PEP.
Discussion/conclusion Issues around clinical record ownership have been interpreted differently across trusts. Locally, when the provider for the SHC changed, minimal patient record information was transferred to the new trust. This limited access contributed to small audit numbers. Compared to previous audit smaller numbers of patients finished the PEP course and attended for follow up HIV test but clinicians have a greater understanding of recommended indications for PEPSE.

P045 SWITCHING FROM BOOSTED ATAZANAVIR (ATV) PLUS FTC/TDF TO A TAF-BASED SINGLE TABLET REGIMEN (STR): WEEK 48 DATA IN VIROLOGICALLY SUPPRESSED ADULTS

[1]Chloe Orkin*, [2]Bart Rjinders, [3]Christoph Stephan, [4]Mehri McKellar, [5]Sasisopin Kiertiburanakul, [6]Jose Arribas, [7]Daniel Murphy, [8]Mark Bloch, [9]YaPei Liu, [10]Marshall Fordyce, [11]Stuart Yau, [10]Scott McCallister. *[1]Barts and The London NHS Trust, London, UK; [2]Erasmus MC, Internal Medicine and Infectious Diseases, Rotterdam, The Netherlands; [3]Universitats Klinikum Frankfurt, Frankfurt, Germany; [4]Duke University, Durham, USA; [5]Ramathibodi Hospital, Bangkok, Thailand; [6]Hospital Universitario La Paz, IdiPAZ, Madrid, Spain; [7]Clinique Médicale l'Actuel, Montreal, Canada; [8]Holdsworth House Research, Sydney, Australia; [9]Gilead Sciences, Inc., Biometrics, Foster City, USA; [10]Gilead Sciences, Inc., Clinical Research, Foster City, USA; [11]Gilead Sciences Ltd, High Holborn, London, UK*

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Background/introduction Tenofovir alafenamide (TAF) is a tenofovir prodrug that contains elvitegravir 150mg/cobicistat 150mg/FTC 200mg/TAF 10mg (E/C/F/TAF).
Aim(s)/objectives This study assessed efficacy and possible bone and renal safety advantages in patients who switched from a TDF-based regimen to E/C/F/TAF.
Methods Virologically suppressed (HIV-1 RNA < 50 copies/ml) adults on a TDF-based regimen for at least 96 weeks were randomised 2:1 to switch to open label E/C/F/TAF or to continue their prior regimen. At baseline, the median CD4 count was 658 cells/uL, the median eGFR(Cockcroft-Gault) was 103.8 mL/min and 10.6% of patients had baseline proteinuria of at least 1+ on dipstick analysis.
Results At Week 48, 390/402 (97.0%) of those who switched to E/C/F/TAF and 183/199 (92.0%) of those continuing boosted ATV plus FTC/TDF had HIV-1 RNA < 50 c/mL (difference, 5.1%; 95% CI: 0.9% to 9.2%). No patients had virologic failure with resistance. In patients who switched, hip and spine bone mineral density (BMD) improved significantly, and proteinuria and specific tubular proteinuria also improved significantly Serum creatinine mean change (μmol/L) from baseline: E/C/F/TAF, +0.88; ATV+ FTC/TDF, +3.54 (p = 0.003). E/C/F/TAF patients had statistically higher changes from baseline in fasted lipid tests; the median change in total cholesterol: HDL ratio was: E/C/F/TAF, +0.2; boosted ATV+FTC/TDF, +0.0 (p = 0.001).
Discussion/conclusion At Week 48, patients who switched from a boosted ATV+FTC/TDF regimen to E/C/F/TAF had a significantly higher rate of virologic control, had significant improvements in hip BMD, spine BMD and in serum creatinine, and also had significantly less proteinuria than those continuing on their TDF-based regimen.

P046 A NEW APPROACH TO QUANTIFYING HEALTH ADVISER INPUT IN A RE-COMMISSIONED SEXUAL HEALTH SERVICE

Sumit Bhaduri*, Carolyn Gosling. *Dept of sexual health, Worcestershire Health and Care Trust, Worcestershire, UK*

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Background/introduction With sexual health services going out to tender, commissioning intentions have prioritised health promotion and prevention strategies. Whilst these activities are currently performed they have been difficult to quantify. Consequently, new codes have been devised to register face to face and telephone input for a) counselling/support/safeguarding issues face to face (HCSF) b) counselling/support/safeguarding via telephone interaction (HCST), c) Health education/health promotion or advice face to face (HEF) d) Health education/health promotion or advice via telephone interaction (HET) e) partner notification face to face (HPNF) and e) partner notification via telephone interaction(HPNT)
Aim(s)/objectives To ascertain whether the newly devised codes have been integrated into routine service
Methods Case notes were analysed over a 3 month period to ascertain, the frequency of use of such codes
Results 37 case notes had input as regards counselling/support/safeguarding face to face (HCSF). 14 had such input via telephone. 75 case notes had input as regards health education/health promotion (HET) face to face, 94 had such input via telephone. 66 case notes had input as regards partner notification face to face, 43 had this via telephone.
Discussion/conclusion It has been established that the codes have been easy to apply and have already given a quantitative view as regards health promotion/education/safeguarding, which has supported discussions with commissioners. It is envisaged that use of the codes will enable of health adviser interventions to be measured time wise. This work will also be presented.

P047 HEALTH CARE NEEDS OF WOMEN AGED 40 AND OVER ATTENDING AN INNER CITY INTEGRATED SEXUAL HEALTH CLINIC

[1,2]Patrice Grech*, [1]Rebecca Marchant, [1,2]Mannampallil Samuel. *[1]Camberwell Sexual Health Centre, London, UK; [2]King's College Hospital, London, UK*

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Background/introduction Sexual health policy is targeted towards younger adults, with national screening programmes and research studies excluding individuals over the age of 44. UK surveillance data demonstrated that rates of sexually