populations for self-testing and framing the campaign within the 'gay scene'.

Discussion

Few participants had previously self-tested Knowledge and generating a 'sense of a testing community' were the most important factors for promoting self-testing. Collaboration with designers and communities ensures a user-centred approach to HIV self-testing.

P079 ARE PATIENTS WITH UNEXPLAINED BLOOD DYSCRASIAS BEING TESTED FOR HIV?

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Introduction The purpose of our audit was to determine whether our hospital is following the BHIVA National Guidelines (2008) and testing for HIV in patients presenting with unexplained blood dyscrasias.

Methods Our initial sample consisted of all inpatients coded as having lymphopenia, thrombocytopenia or neutropenia between 1/1/16 and 1/11/16. We excluded patients with a known cause of cytopenia and those with mild cytopenias (platelets >80, neutrophils >1, lymphocytes>1). In our final sample of 82 patients, we used the electronic ordering system to collect patient and admission information and to determine whether a HIV test was ordered.

Results 37% of patients with unexplained blood dyscrasias were tested for HIV. 60% of patients with neutropenia were tested compared with 42% with thrombocytopenia, 25% with lymphopenia and 20% with mixed cytopenias. Patients with lower blood counts were more likely to be tested for HIV. Patients were more likely to be tested for HIV if they were admitted under the haematology team (55%) compared with those admitted under general medical (31%) or surgical teams (27%). HIV testing declined with increasing age of patients with 67% of those aged under 30 being tested compared with 60%, 56%, 22% and 0% of patients between 31–50, 51–70, 71–90 and over 90 respectively.

Discussion We found that the majority of patients with unexplained blood dyscrasias were not tested for HIV. Our study highlighted several factors that influence whether testing is performed. These include the nature and severity of cytopenia, patient age and the admitting medical team.

P080 DRAMATIC REDUCTIONS IN NEW HIV DIAGNOSES FOR MSM IN ENGLAND ARE NOT UNIFORM FOR ALL ETHNICITIES IN A LARGE LONDON CLINIC

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Introduction Along with many other GUM clinics, we are seeing a reduction in new HIV diagnoses in MSM. Our clinic is based in East London and sees MSM of all ethnicities. Preliminary data analysis suggests that this reduction may not apply to the BME MSM population.

Methods We analysed HIV testing rates from our large London GUM clinics. HIV tests, along with demographic data, sexual risk and ethnicity are collected routinely. We then compared positivity rates between ethnicities in 2015 and 2016.

Results Over 2015 and 2016 there were 48,512 HIV tests performed, of which 12,248 (25%) were on MSM. There was a slight decrease in the number of HIV tests in MSM from 6,688 in 2015 to 5,560 in 2016. We saw a significant reduction in the numbers of new HIV diagnoses in MSM from 43 in 2015 to 25 in 2016. This reduction in new HIV diagnoses was seen in those of white ethnicity (from 30 in 2015 to 15 in 2016) and black ethnicity (from 5 to 3). However, this reduction was not seen in Asian MSM (2 diagnoses each year).

Discussion New diagnoses of HIV are declining in MSM, likely due to treatment as prevention and PrEP. However, it appears that these significant drops are not uniform. Asian MSM may be less likely to engaged with traditional GUM services. Targeted work is needed to engage this group and help reduce HIV diagnoses further.

P081 THE COST OF COST-SAVING HIV DRUG SWITCHES IN A SMALL DGH HIV UNIT

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Introduction In July 2016 NHSE circulated a letter regarding Commissioning for Value and antiretroviral drug switches. The letter noted that 'These switches have been identified as not needing to recall patients to clinic or to introduce additional monitoring arrangements unless clinically indicated or the patient requires further support'. However the e-GFR decreases after starting cobicistat and checking at 4/52 is recommended.

Methods Patients suitable for antiretroviral drug switches were identified by pharmacy, a total of 50 patients (53% of our cohort). A review of the outcomes up to Jan 2017 was undertaken.

Results Eleven patients switched successfully from Kivexa to generic abavavir/lamivudine. Fifteen switched from Atripla to Truvada/efavirenz. Of these, four switched back due to side effects. In one case 4 months of drugs, costing £1384, were wasted. Two patients did not tolerate Rezolsta (AKI & diarrhoea). There were ten extra visits for safety bloods. The first prescription for the switches for all regimens was for two months to minimise waste. Additional staff time was required to generate the prescriptions, and the additional deliveries cost £1215 to date.

Discussion Switches from Atripla to Truvada/efavirenz and from PI/r to PI/cobicistat involved additional costs in terms of staff time, delivery charges and drug wastage. In December 2016, we decided to halt the switches to PI/cobicistat, as it was felt that the cost savings were insufficient to compensate for the additional workload, and also it might be a challenge to switch patients back to two drugs when generic darunavir and atazanavir become available.

P082 IMPLEMENTING AND SUSTAINING HIV TESTING IN ACUTE MEDICINE – RESULTS FROM THE FIRST 2 YEARS

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