1/46(2%) ≥3 drug classes. 4 patients were lost to follow-up (LTFU), all returning within 5 years [1-5].
Discussion There was no difference in mean CD4 pre or post-transition, but the proportion who were suppressed improved post-transition. CDC stage progressed in 3 adolescents. All patients had options for suppressive ART although few were on 1st line. There was no long-term LTFU.

P175 VACUUM THERAPY IN ED: OUTCOMES FROM A SPECIALIST VACUUM CLINIC

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Introduction Vacuum devices are a safe and inexpensive treatment for erectile dysfunction (ED) particularly when other treatments are not tolerated or contraindicated.
Methods Chart review of patients attending specialist vacuum clinic over 2 year period was conducted. Data collected included outcomes with previous treatments and vacuum device.
Results 55 patients (median age of 65 years) were prescribed a vacuum device. The median time from initial assessment at ED clinic to prescription of the device was 18 months. The majority had significant underlying co-morbidities: 25/55 diabetes, 23/55 CVD, 3/55 prostate surgery, 2/55 stroke, 1/55 spinal injury and 1/55 MS. All patients received prior ED treatment with PDE5i inhibitor and/or intracavernosal alprostadil. With regards to PDE5i, 43/55 reported poor/no response, 1/55 failed to tolerate, and in 11 patients a PDE5i was contraindicated. All 55 patients were subsequently offered intracavernosal alprostadil injections however 17 declined. Of the 38 patients who accepted, 27 reported poor/no response, 7 discontinued due to pain and 4 enquired about alternative treatments. On initial assessment at specialist vacuum clinic 32 patients consented to physical demonstration and all achieved an erection suitable for penetration. 36/55 were discharged after their initial vacuum assessment with no re-referrals. Of the19 reviewed only 1 patient discontinued use of the device and 6 patients continued on additional ED treatments.
Discussion Vacuum devices are a well-tolerated treatment option in those who fail or are deemed unsuitable for other treatments. To date, reported outcomes have been excellent with only 1 patient discontinuing use.

P176 CLINICAL PHARMACOLOGY OF THE HIV INTEGRASE STRAND TRANSFER INHIBITOR BICTEGRAVIR

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Introduction Bictegravir(BIC), an investigational, once-daily, HIV integrase strand transfer inhibitor(INSTI) with potent in vitro activity against most INSTI-resistant variants, is currently in development as a single tablet regimen(STR) coformulated with FTC/TAF.
Methods BIC exposure was dose proportional following SD of 25–100mg. Steady-state accumulation was approximately 1.6x, consistent with the observed half-life of approximately 18 hours. Balanced glucuronidation and oxidation contributed to the major clearance pathways. The DDI study showed increased BIC AUC(61-74%) by CYP3A4 inhibitors voriconazole and DRV/COBI but showed a greater increase(~4x) by potent dual inhibitors of UGT1A1 and CYP3A4, ATV and ATV+COBI. Coadministration with a potent CYP3A4/UGT1A1/P–gp inducer, rifampin resulted in a 75% decrease of BIC AUC a lesser reduction(38%) was associated with the moderate CYP3A4/P–gp inducer, rifabutin. BIC was well tolerated at all doses studied.
Results The favourable BIC PK profile supports once daily dosing. DDI results are consistent with its ADME profile in which both CYP3A4 and UGT1A1contributed to BIC elimination. BIC was safe and well tolerated in healthy volunteers.
Discussion The favourable BIC PK profile supports once daily dosing. DDI results are consistent with its ADME profile in which both CYP3A4 and UGT1A1contributed to BIC elimination. BIC was safe and well tolerated in healthy volunteers.

P177 D2B OR NOT D2B: A REGIONAL MULTICENTRE SURVEY IN LEVEL 3 GUM CLINICS OF 'OTHER CONDITIONS REQUIRING TREATMENT'

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Introduction Diagnoses in patients attending GUM clinics are coded using SHHAPT codes. D3 is used for conditions not requiring treatment. It is often taken to mean a negative STI screen; however the code may not reflect the time or expertise required for a consultation with a high risk or anxious individual. The D2b code is used for 'other conditions requiring treatment' for which there is no other appropriate SHHAPT code. D2b codes did not attract funding in the SRH tariff.

This survey aimed to identify the range of complex consultations and non-STI work seen in GUM clinics that were not captured by the coding.
Methods A retrospective case notes review of patients with a D3 or D2b code attending GUM clinics in 2011. Data was gathered on socio-demographic details, SHHAPT codes and other diagnoses, and outcome. The data was analysed using Excel.
Results 594 patients were included (339 D2b, 255 D3). The commonest diagnoses were genital dermatoses 129(22%). Other diagnoses included chronic pelvic and vulval pain (27), other gynaecological and urological conditions (23), prophylaxis of recurrent infections (33), psychosexual and complex consultations including high risk sexual behaviour, sexual assault, and safeguarding referrals (65).
Discussion Following this survey, a list of D2b sub-codes was developed for use in all the regional GUM clinics. Since then, SRHAD codes have been introduced for complex dermatology, urology, and gynaecology conditions. However the continued use of the D2B sub-codes for high risk patients and complex consultations provides valuable data to support commissioning.