

## P112a

### Simultaneous pulmonary and extrapulmonary infection with multiple strains of *Mycobacterium tuberculosis* in an immunocompromised patient: a case report

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We present a case of disseminated *Mycobacterium tuberculosis* (MTB) infection involving multiple MTB strains in a 28-year-old Vietnamese patient co-infected with HIV and hepatitis C. The patient presented with cough, sputum and constitutional upset. Pan-sensitive MTB was isolated from blood, urine, pleural and cerebrospinal fluid. Bronchioalveolar lavage fluid grew both pan-sensitive and Isoniazid-resistant MTB indicating mixed infection with multiple strains within a single anatomic compartment.

Three months following presentation, while on treatment with rifampicin, ethambutol and pyrazinamide, the patient began to complain of increasing headache, nausea and vomiting and recurrent falls. Examination revealed marked ataxa and sustained nystagmus on both left and right gaze. Neuroimaging revealed leptomeningeal tuberculous disease and multiple parenchymatous tuberculomas with obstructive hydrocephalus. MTB isolated from CSF at this time was resistant to rifampicin. Genetic analysis identified this isolate as identical to the original pan-sensitive isolates implying the development of rifampicin resistance while on therapy.

Cases of mixed infection are increasingly recognised and it appears that co-infecting strains of MTB are not necessarily equally distributed between pulmonary and extra-pulmonary sites. This highlights the importance of culture and sensitivity testing and isolate identification of all samples obtained from distinct sites in patients with MTB infection.

## P112b

### A case of prolonged immune reconstitution inflammatory syndrome

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IRIS is a common complication of the treatment of HIV and TB. Symptomatic treatment with steroids is suggested. Leukotriene receptor antagonists exert broad anti-inflammatory effects and may benefit in refractory cases.

**Case report:** A 41 year old Kenyan man presented with gross cervical lymphadenopathy. He was HIV positive with a CD4 of 18. Lymph node biopsy confirmed tuberculosis fully sensitive to antimicrobials. Quadruple therapy with pyridoxine was commenced. ART was started two weeks after TB treatment. He continued to have intermittent pyrexia, increasing lymphadenopathy and persistently raised inflammatory markers. High dose prednisolone and later intravenous hydrocortisone showed no clinical benefit. He required weekly cervical lymph node aspiration and later developed fistulae. Aspirate fluid remained culture negative. Adherence to all therapy was excellent. CD4 count was 59 @ four months. Montelukast was trailed at this stage. Two weeks later, lymphadenopathy had improved and CRP had decreased significantly. He required no further drainage.

However, he deteriorated five weeks later with leg pain and restricted movement. Massive psoas and abdominal abscesses were found and over 1 litre of pus drained (culture negative). Since drainage of the abscesses he has continued to improve.

IRIS can be prolonged and difficult to manage. Montelukast may have a role in its management.

## P112c

### Contact tracing by HIV genotypic resistance test results

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**Introduction:** Genotypic resistance testing is now recommended before starting HAART in HIV disease. The results can accurately identify the source of infection when more than one contact exists.

**Case summary:** A 38-year-old Caucasian heterosexual male tested positive with multi-drug resistant HIV clade C. His current partner is a married HIV-positive African woman with wild-type clade C virus, undetectable on Trizivir since 2002. Genotyping prompted revelation of former partner, another African female who died of AIDS in 2001 while on third HAART regime of d4T/ddI/Kaletra. HIV genotypes were closely related for the index patient deceased female and her ex-husband, strongly suggesting the same source.

RT mutations D67N, T215S/F, G190S, A98G and PR mutation M63I were common to the female and index patients while the two males shared the RT mutations: G109S/G/A, K101/3E/K/R, V35T, E36A, T39E, K173E, Q174R, D177E, Q207E and R211K and PR mutations: M36I, I93L, L93L.

A conscious decision was made not to reveal the link.

**Discussion:** HIV genotyping allows the correct choice of HAART. Using the results for contact tracing is debatable, particularly with the recent criminalisation of non-disclosure of HIV status.

**Conclusion:** Genotypic resistance test results enabled accurate contact tracing in a seemingly unrelated cluster.

## P112d

### Case report: HIV and seronegative arthropathy and role of methotrexate

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**Introduction:** The effects of methotrexate on patients with HIV are not well known. We report a case of a man with a relatively high CD4 count, not requiring treatment with HAART, displaying evidence of immune failure while on methotrexate.

**Case presentation:** We describe the case of a 48 year old British Caucasian gay man who presented with a 2 year history of lower limb synovitis requiring recurrent steroid injections; he became progressively more debilitated. Initially tested negative for HIV. He also complained of early morning back pain for a number of years and HLA B27 confirmed clinical suspicion of Ankylosing Spondylitis (AS).

Repeated HIV testing 2 years after initial presentation confirmed HIV with CD4 count 622 cells/ $\mu$ l (25%) and 41,400 viral load HIV-1 RNA copies/ml.

Initial results suggested that HAART should be withheld. Escalating doses of methotrexate have coincided with evidence of impaired T cell function manifest as widespread Molluscum and violaceous lesions on his 1st MTP joint. Biopsy confirmed Kaposi sarcoma (KS). His arthropathy remains difficult to control; however he now has an AIDS illness requiring treatment with HAART.

**Discussion:** The effects of steroid use in patients with HIV is established as a risk for the development of opportunistic infection and KS. The effects of methotrexate are not as clear and there is very little literature of the interaction between HIV and AS.

## P112e

### A case of optic perineuritis

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A 46-year-old man presented with a 2-month history of headaches, visual obscurations and night sweats. On examination he had widespread lymphadenopathy, a maculo-papular rash and optic disc oedema. Visual acuity and fields were normal. CT brain was also normal, and lumbar puncture revealed a normal opening pressure, with protein 1.3g/l, 94 white cells/ $\mu$ l (100% lymphocytes) and glucose 2.7/5.6 mmol/l (CSF/plasma). HIV serology was positive, with a CD4 count of 260  $\times 10^9$ /l. Syphilis serology was also positive, with the following titres: RPR 1 in 2 and TPPA >1/1280 (plasma), and TPPA 1/320 and a positive RPR (CSF). A diagnosis was made of meningovascular syphilis with optic perineuritis.

Syphilitic optic perineuritis is characterised by optic disc oedema with normal visual acuity, pupillary responses and intracranial pressures, and normal visual fields except for an enlarged blind spot. It is a rare manifestation of neurosyphilis, thought to represent an extension of basal meningeal inflammation to the optic nerve sheaths. It is differentiated from papilloedema by a normal CSF opening pressure, and from papillitis by normal visual acuity and pupillary responses. It has also been described in meningococcal meningitis, viral meningoencephalitis, rickettsial infections and sarcoidosis.

## P113a

### What potential do patients presenting to primary care hold for effective STI control interventions?

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**Background:** There is evidence that up to 40% of new patients in genitourinary medicine clinics seek care in general practice first. This may have an impact on transmission and cure rates.

**Aims:** To compare sexual behaviour, health care seeking behaviour and extent of symptoms between clinic attenders who did, and did not, approach primary care first.

**Methods:** A questionnaire was administered to approximately 8000 patients in 8 sexual health clinics and linked to clinical data.

**Results:** 22.5% of males and 48.0% of females with an STI had first sought care elsewhere, of which 76.0% of males and 76.5% of females had approached primary care. Males first approaching primary care were more likely to report 2 or more partners while symptomatic than those attending clinic directly ( $P=0.03$ ). Symptom duration was  $\geq 7$  days in 85.1% of those first approaching primary care, and 62.8% in others ( $P<0.01$ ) – the association held for males and females.

**Conclusions:** Patients with high risk sexual behaviour often refer themselves to primary care, rather than to specialist sexual health services. Expedited treatment is required for such patients, since attendance at primary care delays definitive treatment, and some patients may fall 'through the net' between services.

## P113

### Expedited partner therapy (ExPT): is it feasible and acceptable to sexual health clinic attenders in the UK?

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**Aim:** To explore acceptability and feasibility of a range of options for rapid treatment of sexual partners of clinic attenders diagnosed with acute sexually transmitted infections (STIs), including treatment without clinic attendance (ExPT).

**Methods:** Exploratory, qualitative, cross-sectional pilot study, using semi-structured, audiotaped interviews, which were thematically analysed.

**Participants:** Purposive sample of 41 patients representing a range of demographic variables and risk factors within an outer London sexual health clinic.

**Results:** Preliminary analysis suggests that clinic users find ExPT a highly acceptable method of partner notification. Both patient-delivered therapy and collection of therapy from community pharmacies are feasible and acceptable options. Users perceived a high degree of motivation to attend clinic for subsequent HIV testing after ExPT. Further detailed analysis will include: preferred methods of communication with partners; communication with partners by mobile phone whilst index is attending, and issues surrounding primary and non-primary partners.

**Conclusion:** Many sexual health services are unable to meet current targets for partner notification for acute STIs. We believe that innovative models of partner management including patient delivered therapy, using modern communication technology, should be evaluated. We present detailed patient consultation data addressing feasibility and acceptability of expedited partner therapy in a high risk population.

## P114

### Yeah but, no but, yeah but ... What information are young Britons getting about sexual health?

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**Background:** The numbers of sexually transmitted infections (STI's) diagnosed in the UK continues to increase, with the highest reported rates in young sexually active persons. Many young women rely on the media including womens' magazines for information about sexual health, and is a commonly cited reason why a young woman presents for STI screening.

**Aims:** To determine the quantity and quality of information about sex and sexual health, in particular STI's in young womens' magazines sold in the UK.

**Method:** This is a prospective study since November 2004. Womens' magazines which target 14–21 year-olds were reviewed for articles concerning sex and sexual health. This study examined the article type, the authors' professional qualifications, and the accuracy of the content.

**Results:** Of the 77 journals reviewed to date, 90% carried articles about sex but only 14% had articles on STI's. In all cases the factual content was correct. The types of infections reviewed, article type authorship will be discussed.

**Conclusion:** Although information about sexual health is common in young womens' magazines, there is far less information about STI's. With the increasing awareness for asymptomatic screening magazines may provide a good vehicle in which to disseminate more information about STI's.

## P115

## Designed by young people for young people: description and review of a specialist sexual health clinic in Hammersmith and Fulham

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**Aims:** To determine the rates of sexually transmitted infections (STIs) and pregnancy in young people attending a specialised sexual health clinic, 'Cont@ct 2', at the WLCSH, from its inauguration in June 2001–December 2003. To describe this unique service designed by young people.

**Methods:** Data was collected prospectively for all Cont@ct 2 attendees, and was analysed using SAS statistical package.

**Results:** There were 1312 attendances from 734 patients, aged 13.6–21.5 years (mean, 17.7). Most were female [572 (77.9%)], 263 (35.8%) were white, and 335 (45.6%) of varying Black ethnicities. The rate of infection with chlamydia was 16.7% (95/572) amongst females, and 17.3% (28/162) amongst males. The rate of infection with gonorrhoea was 5.4% (31/572) and 7.4% (12/162) respectively. There were 378 attendances for contraception. The pregnancy rate was 7.5% (43/572), 25 (57.8%) amongst girls of Black ethnicities. Eight (18.6%) had concurrent STIs at diagnosis. Thirty termination of pregnancy referrals were made for 29 girls.

**Conclusion:** This open-access clinic, operating after school hours, with different registration facilities in a separate clinic area, has found high rates of STIs and teenage pregnancy. The increasing numbers of yearly attendances, testifies to the success of our approach and necessity to expand this service.

## P117

## A description of the sexual risk behaviours of college students when they travel abroad

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**Background:** The number of students travelling abroad is increasing yearly. This study raises the issues of the sexual 'risk behaviour' among college students when they travel abroad.

**Method:** A quantitative study was conducted among undergraduate students. 385 students were invited to participate, yielding a 78% response rate.

**Results:** 30% had casual sex while abroad. Exploring this group showed 35% had unprotected sex, more males than females. 62% who had casual sex abroad travelled with the intention of having sex, 86% were male. Casual sex was more common among single people however; unprotected casual sex was more common with those who were already in an existing relationship at home. The time during sexual intercourse in which a condom was put on varied from before genital contact to after some penetration, increasing risk for sexually transmitted infections. 98% of the college students were under the influence of alcohol and 79% felt they drank excessively. Perception of risks is lower than behaviour suggests.

**Conclusion:** Many perceive their risk as lower than their behaviour suggests. Addressing this behaviour requires a health promotion campaign challenging how holidays are promoted and addressing the influence of alcohol and drugs on sexual health and correct use of condoms.

## P116

## A review of a nurse-led sexually transmitted infection screening service, including laboratory provision, in a young person's clinic after 9 months

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**Aim:** To review the outcome and acceptability of sexually transmitted infection (STI) screening in the setting of a young persons contraceptive service.

**Methods:** Records of all clients who attended a GUM clinic at Liverpool Brook Centre were reviewed.

**Results:** During the first nine months of this new service 666 appointments were attended; 576 (86.5%) were first attendee's, 10 (1.5%) were re-registered clients and 80 attended for follow up. 544 (92.8%) clients received a full screen which in 222 (37.9%) was negative. HIV testing was offered to 560 (95.6%) clients of whom 213 (37.2%) accepted. A partner notification audit of clients seen during the first six months was carried out; 60.7% of known contacts attended for testing and/or treatment. 61 (93.8%) clients from a random sample of 65 completed a client satisfaction questionnaire. A high degree of satisfaction was expressed regarding both premises and staff attitudes.

**Conclusion:** A nurse led STI screening service, including laboratory provision, in a community setting is acceptable to clients. More than 96% of clients seen were managed within the service. Evidence of infection was found in 444 (62.1%); achieved rates of HIV tests offered and contacts traced fell within national targets (DH 2002, SSHA 2004).

## P118

## Sex work practices and condom use in female sex workers in Sydney

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**Objective:** To determine sex work practices, sexual behaviour and predictors of condom use among sex workers (SWs) in Sydney.

**Methods:** Female SWs were recruited from two sexual health centres in Sydney. Participants completed a self-administered questionnaire covering demographic, sexual and reproductive characteristics and sex work practices. The association of each variable with condom use was assessed.

**Results:** 148 International (born in Asia) and 141 Local SWs (born in Australia, New Zealand or the UK) were recruited. 54% of International SWs and 21% Local SWs had worked outside Australia ( $p=0.001$ ). Local SWs saw more clients per shift ( $p=0.002$ ), but International SWs worked more shifts per week ( $p=0.001$ ). Local SWs had more non-paying partners in their lifetime than International SWs ( $p=0.001$ ). International SWs used condoms less consistently at work but more consistently with non-paying partners ( $=0.01$ ) than Local SWs ( $0.001$ ). On multivariate analysis, inconsistent condom use was associated with speaking Thai ( $p<0.001$ ) or Chinese ( $p<0.001$ ) and previous sex work in Thailand ( $p=0.02$ ).

**Conclusions:** International SWs used condoms less consistently than Local SWs. Speaking Thai or Chinese and previous sex work in Thailand were the only independent variables showing an association with inconsistent condom use. Condom use with non-paying partners was poor.

## P119

## Heterosexual men and women are less likely to use the internet to look for sex than gay men

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## P121

## Is advice on condom use from HIV clinic staff associated with sexual risk behaviour among HIV-positive gay men?

G Bolding<sup>1</sup>, M Davis<sup>1</sup>, LL Sherr<sup>2</sup>, G Hart<sup>3</sup>, J Elford<sup>1</sup><sup>1</sup>City University London, <sup>2</sup>Royal Free and University College Medical School London, <sup>3</sup>MRC Social and Public Health Sciences Unit, Glasgow, UK**Aim:** To examine whether advice on condom use from HIV clinic staff (in relation to HIV cross infection or undetectable viral load) is associated with sexual behaviour among HIV positive gay men.**Methods:** HIV positive gay men attending a London HIV outpatient clinic in 2002–2003 were asked to complete a self administered questionnaire ( $n = 483$ , response 72%).**Results:** Two-thirds of respondents ( $n = 319$ ) said they had discussed HIV cross-infection with clinic staff and had been advised to always use condoms for anal sex with another HIV positive man. The remainder had not discussed it. There was no association between discussing this with clinic staff and reporting unprotected anal intercourse (UAI) with another HIV positive man (13% v 13%,  $p = 1.0$ ). Two-thirds ( $n = 304$ ) said they had discussed HIV transmission risk when their viral load was undetectable and had been advised to always use condoms to avoid passing on HIV. There was no association between discussing this with clinic staff and UAI with a partner of unknown or discordant HIV status (26% v 23%,  $p = 0.5$ ).**Conclusions:** Two-thirds of respondents had been advised by HIV clinic staff to use condoms in specific situations but there was no association between receiving this advice and their sexual behaviour.

## P120

## Sexual behaviour of HIV-positive men who have sex with men with gonorrhoea

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**Background:** Bacterial sexually transmitted infections (STIs) are important risk factors for the transmission and acquisition of HIV, together with increasing reports of unprotected anal intercourse (UAI) with casual partners of unknown or discordant HIV status. This may explain the sustained high incidence of HIV in men who have sex with men (MSM).**Aim:** To determine the sexual behaviour of HIV positive MSM with gonorrhoea and estimate the risk of onward transmission of HIV.**Methods:** Retrospective case note review of HIV positive patients with gonorrhoea at a large HIV outpatient centre in London (01/04–09/04).**Results:** 139 patients with gonorrhoea were identified. Preliminary results of 61 patients showed the total number of partners recorded for the preceding 4 weeks was 127 (1–4). Of these, 35% were known to be HIV positive, 50% were of unknown or discordant HIV status 15% missing. 70 (55%) were casual partners. 54% of episodes were UAI. Median viral load was 165756 (200–1680700 copies/ml). Full results will be presented at the conference.**Conclusion:** This study shows the potentially high risk of onward transmission of HIV in MSM with gonorrhoea and the need to offer repeat screening for HIV to HIV negative MSM with gonorrhoea.

## P122

## Surveillance data on HIV and other sexually transmitted infections (STIs) in the UK in 2003: can we reach targets set in the National Strategy for Sexual Health and HIV?

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**Aim:** Current national surveillance data on the intersecting epidemics of HIV and other STIs in the UK will be presented within the context of targets of Sexual Health Strategy to reduce the undiagnosed prevalence and transmission of STIs and HIV.**Results:** Of the estimated 53 000 people living HIV in 2003, 27% were undiagnosed. New diagnoses continued to rise among heterosexual men and women born in sub-Saharan Africa, most acquiring their infection abroad. Sustained high level of new diagnoses in MSM may be partly explained by improved testing (uptake of 47% among MSM attending GUM clinics in 1998 cf 64% in 2003). However, increases in HIV incidence (3.7% of MSM attending GUM clinics in 2003) are of concern. Antenatal HIV screening uptake is now high: >90% of HIV infected women are diagnosed prior to delivery. Prevalence among pregnant women born in the UK remains stable (0.03%). STI trends are difficult to interpret but indicate limited progress in curtailing the epidemic. Compared to 2002, chlamydial diagnoses increased by 8%; genital warts 2%; syphilis 28% in men and 32% in women (cf a 4% decline in gonorrhoea). STIs remain particularly high among young people, MSM and ethnic minority groups.

## P123

## Is there a heterosexual epidemic of HIV in the UK?

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**Aim:** The annual number of new HIV diagnoses in heterosexuals in the UK has increased rapidly in recent years, accompanied by increases in reported risk behaviour and in the incidence of other sexually-transmitted infections. However most of these newly-diagnosed HIV infections were acquired outside the UK. We examine whether there is a self-sustaining HIV epidemic – with continued onward transmission leading to a potential explosion of cases – occurring in heterosexuals in the UK.

**Methods:** We compare annual numbers of new UK-acquired heterosexual HIV cases with the UK prevalence of HIV in heterosexuals, to calculate the average annual number of new infections per prevalent infection. This number must exceed a threshold value for there to be sustained transmission. Since diagnoses reflect past incidence of infection, sensitivity to the delay between infection and diagnosis is examined.

**Results:** The average annual number of new infections per prevalent infection is currently too low for there to be a self-sustaining UK epidemic. However, of concern is the increase in this rate over time, consistent with reported increasing risk behaviour.

**Discussion:** The evidence does not indicate a heterosexual HIV epidemic currently occurring in the UK. However, transmission rates are increasing and there is no room for complacency.

## P125

## STISS: developing a national web-based STI coding system in Scotland

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**Problem:** By 2002 Scottish GUM clinic ISD(D)5 (KC60 equivalent) data collection was 3 years behind due to combination of failing stand-alone IT systems, delays in processing paper-based returns and lack of prioritisation by NHS trusts.

**Intervention:** A Scottish Executive-funded STI epidemiology working group recommended adoption of centralized web-based data collection. The STISS (STI Surveillance Scotland) system was developed by Information Services of National Services Scotland. All clinics were given NHS-net-enabled computers; diagnostic codes were revised to introduce service codes, yielding denominator data. Key advantages include: real-time secure data collection; real-time validation, enhancing data completeness and accuracy; context-sensitive help; flexible revisions to codes; scalability to any number of locations with minimum site visits.

**Outcome:** Web-based coding went live on 22/04/04. By 31/12/04, 11812 records had been submitted from 16 sites, with 60% of clinics in Scotland participating. New mandatory service records were complete for every record. Chlamydia positivity rate was 11.9% in women, 13.3% in men. HIV test uptake rate 51.9% overall, 47.3% in those with acute STI.

**Conclusion:** The new STISS system has greatly improved data collection and quality and allows timeous reporting of STI trends and positivity rates.

## P124

## The use of geographical information software (GIS) in sexually transmitted infections mapping

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**Objectives:** To explore the use of GIS to assess access to genitourinary medicine (GUM) clinics according to ward of residence and to identify areas of high sexually transmitted infection (STI) incidence.

**Methods:** Data from patients aged 15–29, living within a predefined area, attending a GUM clinic from July 2003–2004 were analysed. Attendance rates were calculated using census data. Ethno demographic characteristics were compared between patients testing positive for a non-viral STI (chlamydia, gonorrhoea, or syphilis) and those attending for other reasons. Mapping was performed using ARC GIS ©software.

**Results:** Of the 7442 patients identified, 749 (10.1%) were diagnosed with a non-viral STI. Those with non-viral STIs were more likely to be of black ethnicity (39.5% c.f 26.4%) [ $p \leq 0.001$ ], particularly those with gonorrhoea (63.4% vs. 26.4%) [ $p \leq 0.001$ ] or be male (47.9% c.f 37.9%) [ $p \leq 0.001$ ]. GIS software demonstrated that the highest rates of attendance were from wards in close proximity to the clinic. High disease incidence areas were also clearly demonstrated.

**Conclusions:** GIS is a useful in mapping access patterns of populations to GUM services. It may also have a role in identifying 'hotspots' of disease, thus assisting in targeted disease control initiatives. GIS maps will be presented at the meeting.

## P126

## Follow-up to establish the probable route of infection for individuals diagnosed with HIV between 1997 and 2003 in England, Wales and N Ireland

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**Introduction:** Understanding the epidemiology of HIV infection in the UK requires establishing the transmission route for as many as possible of those diagnosed. The national surveillance process includes standardised follow-up of all cases where the likely transmission route cannot be determined from the case report.

**Methods:** The route of infection categorisations of cases with diagnosed HIV infection were compared before and after follow-up for reports received between January 1997 and December 2003 by examining the up-dated data as it stood at the end of 2004. The contribution of this to the overall understanding of HIV infection in the UK was evaluated.

**Results:** 10,911 reports required following up between 1997 and 2003. At the end of 2004 full allocation to one of the established transmission route categories was achieved for 9,205, 181 had been closed unresolved and for 1,487 follow-up was continuing. Of those allocated to a category, most were infected heterosexually and the follow-up ascertained that the majority of these infections occurred abroad. Thirty-eight cases which did not fall into one of the four main transmission routes were identified.

**Conclusion:** Detailed follow-up provides a more complete understanding of the changing epidemic in the UK, information fundamental to the appropriate targeting of prevention efforts.

## P127



### Late presentation of HIV infection - more evidence of health inequalities?

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**Aim:** To investigate determinants of late presentation of HIV (CD4<200).

**Methods:** Notes review of all new diagnoses of HIV infection in 2004.

**Results:** 84 adults were newly diagnosed HIV antibody positive in our centre in 2004. Late presentation was defined by baseline CD4<200. No significant differences in baseline CD4 count were observed between males and females, although black African men were significantly more likely than black African women to present with advanced disease (p=0.024). Moreover, no significant differences were seen in baseline CD4 count between black African women testing as part of the antenatal screening programme compared to those testing in the GUM clinic setting. Predictably, individuals testing positive as in-patients had significantly worse CD4 counts than those electively testing in the GUM clinic (p=0.007). A higher proportion of antenatal diagnoses had well-preserved CD4 counts compared to those testing in GUM clinic (p=0.037). Duration of stay in the UK at time of diagnosis had no impact on baseline CD4 count.

**Conclusion:** Black African men remain a difficult to reach group for early elective HIV testing. The impression that seeking HIV care drives migration from high prevalence/resource-poor countries would appear to be a largely false one.

## P129



### Patient preferences for partner notification

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**Aim:** To identify patient preferences for notification of sexual contacts.

**Methods:** A questionnaire survey of 2500 patients attending the Genito-Urinary clinics at the participating sites.

**Results:** An interim analysis of the first 1239 respondents is presented.

Demographics	Number (%)
Females	701 (56.6)
White ethnicity	850 (68.6)
Single	885 (71.3)
Heterosexual	1015 (81.9)
Symptomatic presentation	509 (41.1)
Access to private letters	821 (66.3)
Access to mobile telephone	1056 (86.0)
Access to private email	485 (39.1)

The median age was 24 years (range 13–69). The index patient's ratings of the methods of contacting a sexual partner if they are found to have a sexually transmitted infection are as follows:

Partner notification method	Good method (%)	Not a good method (%)
Patient informs partner themselves	915 (84.3)*	59 (5.4)
The clinic sends letters to partners	306 (29.3)**	525 (50.8)
The clinic phones partners	180 (18.2)	696 (68.1)
The clinic sends a text message to partners	139 (13.4)	822 (79.8)
The clinic sends an email to partners	89 (8.6)	849 (84.2)

**Conclusions:** Provider referral is less acceptable to patients than patient referral for partner notification\*. Notifying contacts through a letter seems to be more acceptable than phoning, text messaging or email\*\*.

## P128

Withdrawn as requested

## P130



### Who fails to attend following contact tracing?

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**Aim:** To identify the characteristics of contacts of chlamydia who fail to attend following provider referral.

**Methods:** 217 (151 M; 66 F) heterosexual contacts of chlamydia notified by a health adviser in 2003 from a provincial city GUM were classified according to attendance, age, gender, ethnicity and deprivation score. Postcodes were 'deprived' if below the 20th centile on the Index of Multiple Deprivation Super Output Area Levels. C2 analysis was carried out using Epi Info.

**Results:** 70.9 % of males attended, v 80.3 % females (p=0.20); 74/107 (69.2%) 'deprived' attended v 86/110 (78.2%) less deprived (p=0.18); 65/97 (67.0%) under 20 attended v 95/120(79.2%) over 20s (p=0.06). For ethnicity, differences in attendance patterns were highly significant: 135/157 (86%) of whites compared with only 19/33 (56%) of non-whites (p=0.0004).

**Conclusions:** Poorer outcomes for provider referral are strongly associated with non-white ethnicity, and young age is almost statistically significant; there is a trend for association with male gender and poverty. This gives a useful insight into which populations find access to sexual health services most difficult, and where other control strategies (e.g. screening programmes) may be targeted most effectively.

## P131

## Stakeholder perspectives on delivering sex and relationships education (SRE) in Tower Hamlets

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**Introduction:** Sexpression, a Medical Student International Network initiative is a voluntary, student led society at Bart's and The London medical school. Set up in Tower Hamlets, Sexpression identified a need for targeted, culturally specific Sex and Relationships Education (SRE) in this ethnically diverse community. Working with the PCT and sexual health services, Sexpression recruits and trains medical students to deliver SRE to young people. Trained medical students will provide informal interactive teaching to young people, thus supporting local agencies and schools in the community. Sexpression highlights the need for developing culturally sensitive and relevant SRE in line with the needs of the local community.

**Aim:** Determine stakeholder perceptions of SRE delivery in Tower Hamlets. Determine stakeholders views on the role of Sexpression within context of SRE delivery as a community initiative.

**Methods:** Semi-structured interviews with a cross section of stakeholders including teachers, nurses, youth workers, community leaders, sexual health services managers, parents centre manager, department of education.

**Results:** Qualitative inductive thematic analysis will be presented using data from the semistructured interviews. The results include themes about consumer involvement, cultural sensitivity, and educational content.

**Conclusion:** Data highlights that consumer involvement is crucial for organisational and personnel development of delivery plans for SRE.

## P133

## Psychological and psychosexual impact of HIV infection in an older population

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**Background:** As people become older their sexual habits change. This study is looking at how this affects sexual habits of HIV positive patients. A total of 27 patients aged 60 years and over (Males =23, Females =4) attend the HIV Clinic.

**Aim:** The aim of this study is to identify the psychological and psychosexual impact of a HIV diagnosis in an older patient cohort.

**Methodology:** A mini-mental assessment and a detailed structured questionnaire was performed on the first sequential twelve patients aged 60 years and over. This recorded demographic information, previous medical history, psychological aspects of their diagnosis and the psychosexual impact of a HIV diagnosis.

**Results:** Twelve patients were interviewed (male 9, female 3) mean age 69 years (Range 62–81 years) Risk factor for HIV acquisition was Heterosexual (5) Bisexual (6) Blood transfusion (1). Mini-mental assessment scores ranged from 22–30. (Normal range 25–30). Following their diagnosis, 50% of patients described a new onset of insomnia, 33% of patients described significant anxiety symptoms. Prior to diagnosis nine patients enjoyed sexual intercourse, one enjoyed sex post diagnosis, eight patients no longer had sex because of HIV, four patients described new onset of erectile dysfunction post diagnosis.

**Conclusion:** This study demonstrates a significant morbidity associated with the aging HIV population.

## P132

## One-stop shop versus collaborative integration: what is the way forward?

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**Aim:** To examine models of integrated and/or one-stop shop (OSS) sexual health services (including general practice, mainstream specialist services and designated young people's services), exploring their relative strengths and weaknesses.

**Methods:** Literature review, interviews with key-informants involved in developing the UK's National Strategy for Sexual Health and HIV (n=11), and site observations at services taking part in the national OSS evaluation.

**Results:** Contraceptive and genito-urinary medicine issues are closely related. However, there is no agreement about what it means to have integrated services, about which services should be integrated or where integration should happen. There are concerns OSSs will result in over-centralisation, precluding the continuation of stand-alone and satellite services. OSS models are potentially more user-focused, but the stigma that surrounds sexual health services may create an access barrier. From staff perspectives, the highlights are greater career opportunities and increased responsibility, while the downsides are concerns OSSs will result in loss of expertise and professional status. Parallel services are expensive and limited resources often mean there are reduced opening hours, however data on cost-effectiveness is contradictory.

**Conclusion:** Despite a policy commitment to developing OSS services, the evidence gap around the impact and appropriateness of this approach is substantial.

## P134

## Did the 'Brazilian' kill the pubic louse?

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**Background:** Anecdotes suggest a recent reduction in cases of pubic lice despite increasing patient numbers and increasing prevalence rates of other sexually transmitted infections (STIs). The aim was to determine the prevalence rates of pubic lice between 1997 and 2003, and compare these with rates of gonorrhoea and chlamydia over the same period.

**Methods:** Annual cases of pubic lice, gonorrhoea and chlamydia were obtained for 1997 to 2003. Prevalence rates were calculated by dividing these figures by new patient numbers.

**Results:** The prevalence rates were:

Year	GC	CT	Public lice
1997	1.7%	9.4%	0.41%
1998	1.3%	11.1%	0.43%
1999	1.6%	12.3%	0.39%
2000	2.8%	12.8%	0.25%
2001	2.6%	12.2%	0.27%
2002	3.8%	13.2%	0.30%
2003	3.5%	12.0%	0.17%

Comparing 2003 with 1997 there was a significant drop in prevalence of pubic lice (OR 0.41; 95%CI 0.23–0.70) whereas there was a significant increase in gonorrhoea (OR 2.18; 1.86–3.48) and chlamydia (OR 1.31; 1.21–1.43).

**Conclusion:** Sexual behaviour changes cannot account for this discordant pattern of STIs so there must be another explanation. The drop in pubic lice in women was around 2000 and coincided with the introduction of new trends in pubic hair removal. Full breakdown of the figures will be presented and correlated with pubic hair removal practices.

## P135

### Characteristics of patients declining an HIV test in a genitourinary medicine clinic

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**Aim:** To determine the characteristics of patients who decline HIV testing in a GUM clinic since the introduction of a routine testing policy.

**Methods:** Retrospective case notes analysis of patients declining HIV testing compared to those accepting over a three-month period in 2004. Demographic characteristics, risk behaviour and KC60 diagnostic codes were compared.

**Results:** Of a total of 1996 patients who were offered HIV testing, 797 (39.9%) declined the test. A random sample of 220 (103 accepting, 117 declining) was analysed further. Factors associated with an increased likelihood of accepting an HIV test included same sex relationships for men (odds ratio [OR] 5.01, confidence interval [CI] 1.72 to 14.60) and a discernible HIV risk factor (OR 9, CI 2.40 to 5.07). Declining testing was not associated with gender, a concurrent STI diagnosis or having tested previously. However, 20% of patients declining the test had identified risk factors for HIV infection.

**Conclusions:** A routine testing policy for HIV within GUM clinics does not guarantee universal uptake. While patients perceived to be at risk are more likely to test, a significant proportion of patients with risk factors continue to decline testing. Further detailed analysis will be presented at the meeting.

## P137

### KNOW4SURE – a community-based rapid HIV point of care test (POCT) clinic

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**Aim:** To evaluate an outreach, rapid HIV POCT clinic.

**Method:** We reviewed the case records of all attendees to a community-based, weekday evening clinic offering a maximum of 10 tests per session.

**Results:** 626 individuals attended over 21 months, 73% men, 30% MSM, 0.5% IVDU. The mean age was 31.7 years, and 23% were from BME communities. 96% of responders indicated a preference for evening/Saturday clinics, 87% preferred a walk-in service. 55% had tested before, mean 2.1. 9% were expecting a positive test result, and 26% admitted to high level worry regarding HIV. The availability of a rapid test influenced the decision to test for 96%. Identified risks included unprotected intercourse; 52% vaginal, 16% anal and 16% oral. 60% had a partner of unknown HIV status and 6% a known HIV+ partner. 597 tests were performed, 22 (3.7%) were positive. Recent increase in number of tests and staff has resulted in 30% increased attendance.

**Conclusion:** A large proportion of individuals testing were at low risk for HIV, reflected in the relatively low diagnosis rate. Current interventions are underway to increase the attendance of individuals at higher risk. Rapid testing and 'out of hours' services are preferred.

## P136

### Do differences in access to GUM clinics or HIV testing behaviour of African men and women account for the high proportion of women testing HIV-positive in the UK?

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**Background:** In 2003, 59% of new UK HIV diagnoses were acquired through heterosexual sex, and 65% of these were women, predominantly from Africa. We aimed to determine if this could be due to higher uptake of HIV tests in African women than men, through increased access to our GUM clinic, or being offered or accepting a test more often than men.

**Methods:** All African-born new patients of Black African ethnicity attending between January and June 2004 were reviewed to determine if an HIV test was offered and accepted. Data collected on sex, age, sexuality, presenting complaint and STI diagnosis, was analysed using Chi squared.

**Results:** 234 men and 190 women attended. 95.5% men and 94.6% women were offered an HIV test (p=0.813) and 73.8% men and 72.8% women accepted (p=0.906). 12 men and 12 women tested positive (p=0.517). Asymptomatic patients were significantly more likely to accept an HIV test than symptomatic patients (p=0.009).

**Discussion:** Women and men were equally likely to be offered and accept an HIV test in our clinic. More men than women attended. This study did not demonstrate that greater testing of women than men in GUM accounts for the high proportion of new infections in women.

## P138

### Acceptability of voluntary HIV testing among NHS staff: results from a questionnaire-based survey

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**Background:** Numbers of healthcare workers from high endemicity areas employed by the NHS are increasing. The DoH has guidelines for the responsibilities of HIV infected staff but none for universal voluntary testing of healthcare workers.

**Aims:** To assess the acceptability of voluntary HIV testing for NHS staff.

**Methods:** Anonymous questionnaire to staff at a London DGH.

**Results:** Of the first 69 respondents: 75.4% were female, 23.3% male, 1.4% no data available (NDA). Ethnicity: 11.6% black British, 30.4% white British, 8.7% Asian British, 5.8% Caribbean, 11.6% African, 11.6% Asian, 2.9% black other, 13% white other and 4.3% NDA. 38% were nurses, 19% doctors, 16% clerical/administrative, 7% healthcare assistants, 20% other. 92.4% understood the terms HIV/AIDS, NDA 5.8%. 39% had a previous HIV test. None were known HIV positive. 42% worked in areas offering routine HIV testing, 55% did not, NDA 3%. 62% would consider having an HIV test, 38% would not. Of the 62%, reasons given were:

	all like to know	benefits from treatment	could tell family	Combination of (a + b + c)	Other
% Respondents	38	9	3	47	6

Of the 38%, reasons given were:

	Rather not know	Effect on family + Rather not know + Losing job + Fear of treatment + Life insurance + Confidentiality	Effect on family + Rather not know + Fear of treatment + Fear of death	Losing job + Life insurance	Other	No data available
% Respondents	11	6	6	12	33	6

## P139

## Effects of restrictions to HIV-positive people travelling to the USA

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**Background:** The USA bans entry to non-citizens with HIV unless they obtain a waiver visa.

**Aim:** To establish how many people with HIV infection travelled to the USA, whether they were aware of the travel restriction, whether they travelled with a waiver visa and medical insurance, how they managed with their HAART and their feelings towards the ban.

**Design:** Cross sectional study, using a structured self-completion questionnaire.

**Results:** 408 questionnaires were returned (73%). 99 (24%) had travelled to the USA since testing positive of whom 83% took out medical insurance, 64% were aware of the waiver visa, and 76% were on HAART. Of those taking HAART, 10% posted their medicines before travel, 47% took their drugs on time, 32% took a doctors letter, and 16% were searched. Only 5% of patients obtained a waiver visa before travel with 9% discontinuing their medication before entering the USA. Many patients reported negative practical and emotional experiences resulting from the travel restrictions.

**Conclusion:** The majority of HIV patients travel without the waiver visa, many with insufficient planning and advice; in nearly 10% of patients, this led to discontinuation of therapy without medical advice.

## P141

## Non disclosure of HIV-positive status

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**Objectives:** To examine the social and demographic status of patients who have reported sexual contacts without disclosure.

**Methods:** From Jun 04–Nov 04 patients were interviewed in depth by medical social workers (MSW) to establish patterns of non-disclosure and thereby facilitate contact tracing.

**Results:** 22 HIV+ heterosexuals, (9 male, 13 female) of whom 5 (23%) identified their source of infection as IVDU, were interviewed. 18 had received post-test counselling. 16 (73%) reported being in a relationship >6 months, (4 married, 7 co-habiting.) 17 denied any casual sexual contacts. 12 report to be sexually active, 10 of these reporting regular condom use. 14 partner contact details were withheld. In 11 cases, disclosure occurred within the first 6 months of strategic disclosure intervention. The majority of disclosures were undertaken by patients (n = 9). 1 by a third party and 1 through anonymous contact tracing. 11 have yet to disclose and work is ongoing. Factors impeding disclosure include fear of relationship breakdown (n = 14) and domestic violence (n= 5).

**Conclusion:** This research revealed a complex and broad range of difficulties around the issue of disclosure. This may necessitate a considered, individualised approach when working on disclosure issues and the need for further research.

## P140

## What impact can an HIV conference have on the lives of people living with HIV?

B Evans

On behalf of the four *Changing Tomorrow* conference partners: National AIDS Trust; National Long-Term Survivors Group, Positively Women, UK Coalition of People Living with HIV and AIDS, UK

**Aim:** To investigate whether *Changing Tomorrow* had an impact on the lives of participants.

**Methods:** 208 pre-conference questionnaires completed, an independently assessed evaluation of the conference and post-conference questionnaires.

**Pre-conference findings:** Only 5% of participants said they were in poor health. 70% were taking HIV treatment, however 85% worry about long-term effects. A further 9% are put off as a result. 70% were satisfied with both their treatment and experiences of health care. Only 6% were unhappy with their specialist HIV care. White people rated their understanding of the NHS higher and had more confidence to get involved. A disproportionate number of heterosexual men were not satisfied with many aspects of their life. Most participants had told somebody about their HIV status, only 13% receiving a negative reaction.

**Conference evaluation findings:** 65% felt more confident about disclosure. 97% stated intentions to take further action (involvement in the NHS, being proactive about health, increasing levels of optimism).

**Post-conference findings:** analysis of post-conference questionnaires identified actions taken by participants and changes in attitudes and behaviour; 44% were less worried about the long-term effects of HIV medication; moderate levels of involvement had increased by over 40%; 51% were more satisfied with the overall quality of their life; 46% were eating more healthily.

**Conclusion:** *Changing Tomorrow* had a significant impact on the lives of participants living with HIV.

## P142

## HIV opt-out increases the offer and uptake of HIV tests in patients at low risk for HIV (LRP) in a genitourinary medicine (GUM) clinic

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**Aim:** To evaluate the effect of introducing HIV opt-out testing for patients assessed as LRP on test offer and uptake rates in the John Hunter Clinic (JHC).

**Methods:** The case notes of 100 consecutive new attendees at 3 clinics (JHC,C2,C3) were reviewed before (T1) and after (T2) the introduction of HIV opt-out testing in JHC.

**Results:** The notes of 600 patients were reviewed, 319 were male, 23% MSM, mean age was 29.4 years. The offer of HIV tests rose in JHC vs C2+3 (88 to 94% vs 85 to 83%, p<0.001). The number of LRP offered a test increased in JHC T1 vs T2: 64 vs 80%, p=0.012. The number of tests performed increased in JHC vs 2+3, for all patients 70 vs 56%, p=0.045, for LRP 72 vs 52% p=0.003. Of LRP in JHC offered a test, uptake did not change, 77%.

**Conclusion:** The introduction of HIV opt-out for low HIV risk patients increased the number of HIV tests offered and performed. The increase in LRP uptake appears to be due to increased offer rather than increased proportion accepting the offer, suggesting this was not influenced by a change in staff input beyond the opt out process.

## P143

### HIV testing and the sexual health strategy: are we 'targeting' the right people?

*L Reeves, M Poulton, M Tenant-Flowers  
King's College Hospital, London, UK*

**Aim:** To investigate whether national targets for HIV testing are being achieved and whether those at high risk test.

**Method:** A retrospective audit of patients attending for an STI screen during one week with collection of risk data.

**Results:** The notes of 333 patients were reviewed. New patients: 95% offered HIV testing with 57% uptake. Of 125 re-attending patients 45% tested for HIV: 44% not offered and 50% declining a test had never tested. All 11 gay men and one female commercial sex worker accepted a test. Black patients were significantly less likely to test than White patients when attending for a first screen ( $p = 0.016$ ). This relationship remained significant only for Black Caribbean patients amongst all Black ethnic groups. The testing uptake for those reporting >1 or 1 or 0 sexual partners in the previous three months was not significantly different. Overall 33% of those diagnosed with an STI also had an HIV test.

**Conclusions:** National strategy targets for HIV testing can be achieved but do not necessarily result in uptake of testing amongst those at high risk. Further work is needed to identify ways to increase uptake in certain groups. Sensitive, non-invasive testing may offer a solution.

## P145

### Successful implementation of a new HIV testing service in an inner-city primary care practice

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**Background:** The national strategy for sexual health and HIV supports outreach services to target risk groups with high rates of undiagnosed HIV. We started a weekly community HIV testing service in Southwark, incorporated into the new patient health check, targeted at the African population. It is run by practice nurses following training by the STI Management in Primary Care Project, supported by the community health adviser.

**Methods:** All new patients registering with the practice are offered HIV testing. Data was collected on age, ethnicity, country of birth, acceptance of HIV test, HIV result and attendance for results from the first 3 months of the service, 2004. One year data will be presented.

**Results:** 6 women and 11 men attended. 8/17(47%) were Africans and 2/17(12%) Jamaican. 16/17(94%) had not tested for HIV previously. All attendees accepted an HIV test following pre-test discussion. 2/17(12%) patients tested HIV +ve. 12/17(71%) DNA'd their result appointment.

**Discussion:** It is possible to set up an HIV testing service in collaboration with primary care colleagues, which successfully targets at-risk individuals who have not previously tested for HIV. Given the high DNA rate for results, alternative methods of informing patients of their results should be considered.

## P144

### Bridging the gap – reducing undiagnosed HIV infection through targeted training in non-specialist settings

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**Background:** Late diagnosis of HIV is associated with poorer outcome to treatment. Many 'late presenters' have previously received care by specialities without HIV being recognised. To attempt to reduce such late diagnosis we constructed an interactive training package on HIV testing with individualised case studies for each speciality.

**Methods:** Questionnaires were completed to determine attitudes and barriers to HIV testing. HIV testing patterns were measured for 3 monthly periods both prior to and after the training package and any positive diagnoses were noted.

**Results:** 6 specialities undertook the course, totalling 57 participants. 54% had previously performed an HIV test. Commonest barriers were uncertainty regarding testing procedure, concern about raising patient anxiety and giving a positive result. Confidence in testing increased from 17.5% to 47.3% after the course. HIV tests performed during 3 month periods before and after the course was essentially unchanged (20 vs 19). However 3 new HIV diagnoses were made, in the post-course period. A further 18 patients were referred to GUM for testing, of which 3 tested positive.

**Conclusions:** A focused course improves confidence in HIV testing and targeted referral to GUM. It has minimal effect on testing frequency but may assist in identifying a small number of infections.

## P146

### Uptake of HIV test is enhanced by a special post-carnival 'KNOW4SURE' clinic offering rapid HIV point-of care testing (POCT)

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**Aims:** To evaluate the effect of providing specific event-related HIV testing clinics following targeted promotion at a community event, and the effect of offering rapid HIV testing at one of the clinics.

**Method:** Two one-off HIV testing clinics were held following promotion to Black and Minority Ethnic (BME) communities at the Notting Hill Carnival. A Saturday clinic offering rapid HIV POCT was held at the Lighthouse West London (KNOW4SURE) and a Thursday evening clinic offering standard HIV testing was held at the Homerton Hospital (HH).

**Results:** 17 people attended KNOW4SURE, none attended HH. Eight were male, 14 heterosexual and the mean age was 32.1 years. 73% identified themselves as being BME, compared to 24% of those attending the regular weekly 'KNOW4SURE' Monday evening clinics held at the same location ( $p < 0.001$ ). 10/10 (100%) attendees preferred evening or weekend clinics. 12/13 (92%) were influenced by the availability of one hour testing and 7/13 (54%) would not have tested had it not been available.

**Conclusion:** Promotion of an event specific clinic increased the proportion of individuals from a target population attending. The availability of rapid HIV POCT appears to influence testing behaviour.

P147

## Unusual mode of transmission of HIV

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We report an unusual case of HIV transmission that would be missed by traditional assessment of risk.

A 39 year old Caucasian man developed flu like illness with symptoms of lethargy and weakness, August 2002. Persistent lymphadenopathy lead to HIV being considered January 2003. A subsequent HIV test was positive. He has one lifetime female Caucasian partner. He had no past history of blood transfusions or IVU. Of note his 37 year old brother had contracted HIV in Botswana via heterosexual contact two years previous. He was on HAART (combivir and nevirapine) and had a CD4 350 (16%) with viral load 4800 (log 3.68). A bloody fight had occurred between them July 2002. Post exposure prophylaxis was not considered. To determine if this was the mode of transmission phylogenetic analysis was undertaken. Analysis of the pol gene region indicated that samples from both brothers belonged to the subtype C clade of HIV-1, and that the sequences were closely related to one another. We present this subject to highlight the importance of careful history taking. Exposure risk data is extremely useful in helping counsel patients prior to HIV testing but as this case illustrates must not be used in a rigid way.

P149

## The complexity of travelling with HAART

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**Aim:** To investigate the issues of antiretroviral therapy in the context of foreign travel

**Methods:** Retrospective questionnaire based survey of HIV positive individuals attending the Bloomsbury HIV outpatient clinic.

**Results:** 72% (n=216) of study participants were on HAART, 4% had started therapy less than 4 weeks prior to travelling and 8% less than 3 months. 5% were on a triple nucleoside, 26% on a PI, 64% on an NNRTI and 5% on a PI/NNRTI regimen. 12% stopped HAART for the duration of their holiday. 26% reported side-effects to HAART prior to travelling, 8% had worsening and 2% new side-effects during their trip. 81% reported no change in adherence, 11% worse and 8% better adherence to medication whilst travelling. 14% reported storage problems and 15% were searched and questioned at border entry point. Nobody had been refused entry. 38% of patients travelling were unaware of potential drug interactions.

**Transport to destination:** 81% carried medication in their hand-luggage, 32% in their suitcase, 6% mailed HAART to their destination. Individuals used a variety of ways to adapt to time zone changes.

**Conclusion:** Travelling on HAART has many complex issues and needs appropriate discussion with the HIV positive individual.

P148

## Non-disclosure of previously known HIV seropositivity in patients newly diagnosed with HIV infection

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We present a case series of five individuals who had previously been diagnosed with HIV, who then re-presented for HIV antibody testing and subsequent treatment without disclosing their HIV positive status. All patients were of African origin. Reasons for non-disclosure included fear of discrimination, immigration worries and concerns as to how they may be treated. Non-disclosure can lead to failure to recognise pre-existing antiretroviral drug resistance and toxicities, failure to address relevant social problems and inappropriate antenatal treatment increasing the risk of mother-to-child-transmission. Antiretroviral resistance already documented in several sub-saharan African countries is likely to increase with expanded access to treatment. Clinical clues such as a raised mean cell volume and lipodystrophic morphology raised suspicion in our cases. Deranged lipid profiles or pigmentation are other indicators. The supposition that patients with low viral loads may have a non-B clade viral subtype may not always be accurate. Therapeutic drug monitoring and genotypic resistance testing can also be useful. Three out of our five cases had extensive multi-class resistance. In all cases, disclosure occurred after multiple clinic attendances. Clinicians should consider the possibility of HIV status non-disclosure and previous exposure to antiretrovirals when seeing newly diagnosed patients with HIV.

P150

## How accurately do patients with HIV know their viral load and CD4 cell count?

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**Aim:** To examine how accurately HIV positive gay men recall their most recent CD4 cell count and viral load test result.

**Methods:** 523 HIV positive gay men (72% response rate) attending a London HIV outpatient clinic in 2002–2003 completed a self administered questionnaire in which they reported their last CD4 cell count and viral load test result. Self-reported data were compared with corresponding data abstracted from patient records.

**Results:** Four out of five men said they knew the result of their last CD4 cell count (404/519, 78%) or viral load test (428/518, 83%). Half the men (51%) who said they knew their last CD4 cell count correctly reported it to within 50 cells/mm<sup>3</sup>. The remainder under- or over-estimated their CD4 cell count by more than 50 cells/mm<sup>3</sup> (27%, 21% respectively). Most men who knew their viral load test result correctly reported it as being detectable or *undetectable*; 95% of the 269 men with a laboratory-confirmed undetectable viral load, and 91% of the 126 men with a laboratory-confirmed detectable viral load correctly reported this.

**Conclusion:** Most HIV positive gay men correctly reported whether their viral load was detectable or not and half knew their CD4 cell count to within 50 cells/mm<sup>3</sup>.

## P151

### Diagnostic value of bone marrow (BM) sampling in HIV-infected patients in the era of HAART

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**Aim:** To assess the diagnostic value of BM sampling in investigation of HIV infected patients since availability of HAART.

**Results:** 114 consecutive patients underwent BM sampling between 1999 and 2004. BM aspirates were normal or non-diagnostic, apart from lymphoma in one and mycobacterial infection in two patients; culture identified mycobacterial infection in nine. BM trephine had a diagnostic yield of 26.1 % in patients with fever and cytopaenia [mycobacteriosis in 13.9 %, lymphoma in 6.2 %, Castleman disease in 3 %, 'drug effect' in 3 %], a yield of 20 % in patients with fever, but no cytopaenia [mycobacteriosis in each case] and a yield of 19.1 % in patients with cytopaenia in the absence of fever [lymphoma in 4.8 % and 'drug effect' in 14.3 %]. For investigation/staging of lymphoma diagnostic yield was 36%. Diagnostic yield from BM sampling was 30.2% in patients receiving HAART and 22.5% in those not receiving HAART. BM sampling was of most diagnostic value in patients where fever and cytopaenia coexisted in the absence of localizing signs of infection, and in the staging/investigation of lymphoma.

**Conclusions:** BM sampling continues to have a diagnostic utility in HIV infected patients in the era of HAART.

## P153

### HIV infection and sexually transmitted infections among persons with insecure immigration or seeking asylum in the UK

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**Background:** Recently over 30% of new HIV infections diagnosed in the UK are in those born outside this country. An increasing work load in GU Medicine clinics arises from individuals with insecure immigration or seeking asylum.

**Aim:** To determine the prevalence of HIV infection and other STI's in an immigration removal centre in the UK.

**Method:** From April 2004 a sexual health screening clinic was established in a male immigration removal centre.

**Results:** To date 99 individuals have attended, representing 15% of the total inmates. The majority (74%) were from African countries and the mean age was 29 years. 16% had previously had a negative HIV antibody test. 40% admitted to sexual intercourse with a UK national. During the study 4 new HIV, 3 latent syphilis, 2 gonorrhoea and 1 chlamydia infections have been diagnosed.

**Conclusion:** A small proportion of the group were diagnosed HIV antibody positive, yet its prevalence (4%) is higher than that of the general population in the UK. A smaller number of STI's were diagnosed yet in all cases these were asymptomatic. In view of this higher level of serious infection targeted screening services should be made available at an early stage to this group.

## P152

### Vitamin D deficiency in HIV-seropositive individuals

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**Background:** Vitamin D levels are associated with immune system differentiation and function. Nutritional deficiencies are common in HIV sero-positive individuals. Little information is however available on the incidence of Vitamin D deficiency in HIV sero-positive individuals or its impact on immune function.

**Methods:** Vitamin D levels (assayed by immunoassay), basic demographic data, CD4 T-lymphocyte counts and HIV viral loads obtained at the same visit were recorded for 43 sero-positive individuals.

**Results:** 63% were male and the median age was 39 (range 23–63). The median CD4 T-lymphocyte count was 363 (range 19–1127) with 8 (19%) of individuals having a CD4 count < 200 cells. 27 (63%) of individuals were receiving HAART with a low or undetectable viral load. The median Vitamin D level was 38.3 (range 11.9–124.8 nmol/L). According to local guidelines one individual (2.3%) had severe vitamin D deficiency (<15nmol/L) and 11 (25.3%) had mild deficiency (15–30 nmol/L). The median CD4 counts in the deficient group was 311(19–663) vs. 416 (131–1127) in the non-deficient group. This represented a weakly positive (r=0.17) but not significant correlation.

**Conclusions:** Mild vitamin D deficiency is common in HIV positive individuals and shows a weakly positive correlation with CD4 T-lymphocyte numbers.

## P154

### Five years of non-occupational post-exposure prophylaxis (NONOPEP) in a south London teaching hospital

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**Aim:** An observational study of non-occupational post-exposure prophylaxis (NONOPEP) prescription.

**Methods:** Data was collected from NONOPEP recipients managed in a South London Genitourinary clinic between 1st Jan 2000 and 1st Dec 2004.

**Results:** 101 patients received NONOPEP. These were predominantly white (81%), homosexual (57%) and male (82%), of median age 33yrs (range 20 to 65yrs). 44% initially attended Casualty. 33% prescriptions were given during the last six months alone. Exposure type was usually sexual intercourse (75%) [anal(56/76), vaginal(18/76)]. 74% sexual exposures received NONOPEP in accordance with BASHH guidelines. 91% sexual acts were consensual of whom 68% knew their source. Antiretroviral therapy and HIV viral load of 'known' sources was reported in 43% and 29% respectively. 88% received combivir/nelfinavir. 45% completed the course. Side effects were experienced by 56% and were the predominant reason for therapy discontinuation. Median 'exposure to NONOPEP' time was 19.5hrs. No patients seroconverted although, only 46% attended for 3m/6m HIV testing. 75% received baseline HIV testing. Baseline screening identified one patient infected with Hepatitis C.

**Conclusion:** NONOPEP prescription has increased in the last six months possibly due to enhanced public awareness. NONOPEP is prescribed following predominantly 'high-risk' exposures with recommended combinations. Follow up attendance rates are poor.

## P155

## Impact of BASHH guidelines upon PEP provision following sexual exposure to HIV

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**Background:** BASHH guidelines for post exposure prophylaxis (PEP) following sexual exposure to HIV outlines when PEP is recommended (R), should be considered (C) or not recommended (NR).

**Aim:** To establish whether introduction of the guidelines has influenced prescribing practice.

**Methods:** Retrospective case note review of individuals requesting PEP pre- (21/3/03-20/3/04) and post-introduction of the BASHH guidelines (17/7/04-31/12/04). Demographics, exposure characteristics and clinical data were collected. Prescribing practice was classified: 1/R, 2/C or 3/NR according to the guidelines.

**Results:** Pre-guidelines 97 individuals requested PEP, of which 51/97 (52.5%) followed sexual exposure. 48/51 (94.1%) started PEP: 40/48 (83.3%) were classified as R, 5/48 (10.4%) as C and 3/48 (6.25%) as NR. Following introduction of guidelines 100 individuals requested PEP of which 80 followed sexual exposure. Data were available for 69. 62/69 (89.8%) started PEP: 52/62 (83.8%) were classified as R, 8/62 (12.9%) as C and 2/62 (3.2%) as NR. Overall only 5/110 (4.5%) who received PEP were classified as NR.

**Conclusions:** The majority of PEP is issued within guidelines and since their introduction prescribing practice appears unchanged at MMC. Practice may be most influenced by these guidelines outside GUM settings or where prior demand has been low.

## P157

## STI self-treatment, STI prophylaxis and auto-PEP

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**Aim:** To determine the extent of self-initiated treatment and prophylaxis for STI and partner initiated HIV post-exposure prophylaxis (PEP)

**Methods:** Anonymous questionnaires were given to 150 consecutive patients in two inner London clinics.

**Results:** A 70% response rate (n = 105) was obtained in the GU clinic. Of these individuals 55% were male, 24% described themselves as homosexual/bisexual, 5% were HIV positive and 49% had a previous STI. Ten percent reported treatment outside the healthcare setting and another 5% self-initiated antibiotics as STI prophylaxis. GP treatment was reported in 11%. In the HIV clinic, a response rate of 64% (n = 96) was obtained. Of these individuals 93% were male, 84% described themselves as homosexual/bisexual and 84% had a previous STI. Three percent reported STI treatment outside the healthcare setting and another 6% self-initiated STI prophylaxis. STI treatment outside the GUM setting (by GP or HIV physician) occurred in 26%. Three respondents reported giving anti-retroviral treatment to a partner as HIV prophylaxis ('auto-PEP') without medical supervision.

**Conclusions:** STI self-treatment and prophylaxis is reported by a significant proportion of clinic attendees. Further research, especially in the community, is required to determine the full extent and implications of this practice.

## P156

## Impact of raising awareness of post exposure prophylaxis for HIV infection following sexual exposure

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**Background:** Terrence Higgins Trust launched a campaign promoting awareness of post exposure prophylaxis (PEP) following sexual exposure to HIV in July 2004.

**Aims:** Determine the campaign's impact upon demand for PEP in two GUM clinics.

**Methods:** Retrospective case notes review of individuals requesting PEP in 2004. Comparisons between demographics, clinical data, exposure characteristics and campaign awareness pre- and post campaign were made.

**Results:** 216 individuals requested PEP (165 MMC, 51 Brighton). Data were available for 196/216 (90.7%). The proportion following sexual exposure significantly increased after the campaign (pre- 49/89 (55.1%), post- 90/127 (70.9%) (p=0.025)). 126/139 (90.6%) commenced PEP following sexual exposure. There was a trend towards more men reporting unprotected anal intercourse (UPAI) with a partner of unknown HIV status (11/24 (45.8%) pre- and 41/72 (56.9%) post-campaign (p=0.48). The campaign was cited by 30.7%. Mean time to initiation of PEP was unchanged (30.4 vs 31.5 hours) and completion rates poor (47.8% vs 48.8%) pre- and post-campaign respectively. Attendances for PEP following sexual exposure at MMC have increased significantly since 1997 (8 in 1997 to 121 in 2004 p<0.001).

**Conclusion:** Post-campaign demand for PEP following sexual exposure has significantly increased. Time to initiation and completion rates remain unchanged.

## P158

## Experience in providing technical assistance to the ARV Roll-Out Program in Kwa-Zulu Natal (KZN), South Africa: The Kings College-Nelson Mandela University Partnership

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**Background:** In 2004, one of the largest Anti-retroviral (ARV) roll-out programmes worldwide was initiated in Kwa-Zulu Natal (KZN). A key challenge is the shortage of health care workers (HCW) trained in ARV use. We have established an institutional partnership to provide ARV training to participating sites. We report our initial experience and evaluation of ARV roll-out at one of the 12 nodal roll-out sites – Port Shepstone Hospital (PSH).

**Methods:** The initial Kings College programme has been led by a consultant team and an SPR on a ten week attachment to PSH, liaison with LC at PSH and RP in Durban.

**Results:** Between 08/04 and 12/04 160 patients started ARVs at PSH. Key achievements included the introduction of structured and standardized approaches for initial visits and monitoring; strategies for improving clinic access for infected HCWs; an audit of reasons for drop-out of the ARV training programme; and optimising OI treatment protocols. 7 HCWs at PSH have been trained in ARV use through tutorials, lectures and direct clinical supervision.

**Conclusions:** The partnership has contributed to improvements in both clinical care and streamlining of clinic operational procedures at PSH. We plan to extend to additional sites in 2005.

## P159

### Why do HIV-positive patients drop out of ARC access programmes? Experience from a newly established ARV clinic in Kwa-Zulu Natal (KZN), South Africa

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**Background and Aims:** Eligibility criteria for Antiretroviral therapy (ARV) in the newly established KZN government ARV programme include: CD4 count <200 copies/ml, disclosure of HIV status, and completion of 3 HIV/ARV educational sessions. We aimed to identify factors associated with drop-out during pre-treatment education at a district hospital.

**Methods:** We retrospectively analysed the log of patients referred for ARVs and completing 3 training modules between 09/04 and 11/04.

**Results:** 173 patients were referred. 118 (69%) were female. Mean CD4 count and age at first visit were 196 (SD 133) and 31.8yrs (SD 9.2). 64 (37%) had CD4 count >200. 173 patients completed module 1, 147 (85%) module 2, and 129 (75%) module 3. Univariate analysis showed no association between drop-out and gender or CD4 count. However, patients aged 20-30yrs were less likely to drop out (7%) than those younger (30%) or older (27%) ( $p=0.018$ ). 3 patients died during training.

**Conclusions:** One-quarter of patients referred for treatment did not complete the prerequisite training and were therefore ineligible for ARVs. Young adults were least likely to drop out. Qualitative interviews are in progress to further explore reasons for drop-out. Preliminary data suggest travel distance and transport money as obstacles to attendance.

## P161

### Reaching the parts free ARVs do not reach: a sustainable UK sponsorship programme for staff with HIV in a Tanzanian hospital

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**Aim:** To establish a programme at a district hospital in Tanzania to provide HIV positive staff with antiretroviral (ARV) treatment whilst government programmes are not supplying free ARVs.

**Background and Method:** Muheza Hospital serves a rural population of 280,000 in north east Tanzania. The UK charity Medicines for Muheza (MforM) provides up to 9% of the annual hospital income. In 2001 there was a death every month from HIV amongst the 316 staff and in 2002 a programme for ARVs began with new regular donors sponsoring individual staff through MforM. Treatment follows WHO guidelines using generic ARVs.

**Results:** 25 patients entered the programme, of whom two died of advanced HIV after a short time, and two more are not on ARVs. Twenty-one staff are on ARVs, 15 on stavudine, lamivudine and nevirapine (Triomune) and 6 on zidovudine and lamivudine (Duovir) with efavirenz. Three are temporarily off work because of tuberculosis and 18 are well and working. Staff morale has improved, and HIV stigma has decreased. Free ARVs remain unavailable, but the success of the scheme encourages recruitment of new donors in the UK to keep pace with entrants to the programme.

**Conclusion:** A sustainable ARV programme has provided great benefit to hospital staff. Expertise in HIV management, monitoring, dispensing, and adherence support have been developed in readiness for an extensive programme when free ARVs become available.

## P160

### Why are HIV-infected care workers reluctant to attend an ARV clinic? Experience from the Port Shepstone Hospital Rollout Programme in Kwa-Zulu Natal, South Africa

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**Background and Aims:** HIV seroprevalence in Kwa-Zulu Natal (KZN) is 36% and 16% among health care workers (HCW). A dedicated ARV clinic was established at Port Shepstone Hospital (PSH) in 08/04, where an estimated 200 HIV-infected HCWs work. By 11/04 only 2 staff had presented for ARVs. We investigated the reasons for reluctance of staff to attend the ARV clinic, and identified strategies to improve attendance.

**Methods:** A confidential, anonymous 20-item questionnaire available in English and Zulu, was randomly distributed to 200 HCWs at PSH.

**Results:** The response rate was 79%. The main reasons given for non-attendance were: concerns about confidentiality and stigmatisation (75%); lack of awareness of their HIV status (56%); unaware of the existence of the clinic (44%); and poor knowledge about the benefits of ARVs (54%). Motivating factors for staff to attend were the ability to see ARV physicians privately (73%), the provision of an off site (58%) and out of hours clinic (34%).

**Conclusions:** Concerns about confidentiality remain a key barrier to improving HCW access to ARV therapy. Strategies in progress at PSH include a staff education programme on the benefits of ARVs and knowing your HIV status, and the establishment of an off-site clinic.

PA1

PA3

PA2

PA4