

## PA1

## Clinical nurse specialist led GUM service for HIV-positive men

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**Introduction:** Evidence suggests high rates of STIs in HIV positive men. A nurse practitioner led clinic was established in June 2004 to improve GUM screening access, opportunities to discuss safer sex, PEP and ensure adequate hepatitis A & B vaccinations.

**Method:** 125 HIV positive men attended this clinic between June–August 2004. Retrospective data was collected from 66 notes using a specially designed audit tool.

**Results:** The clinic was utilised mainly by 125 HIV positive men, who were mainly white (n = 40) and homosexual (n = 61). Mean CD4 541; 34 men were on antiretroviral therapy. 14 men had received STI screening in the last year. The average number of sexual partners in the preceding 3 months was 13 range 1–450. 30 men had an STI diagnosed requiring treatment including gonorrhoea (12), early syphilis (2) and epidemiological treatment for syphilis (2). None of the men audited used condoms for anal sex. Safer sex was discussed with all men. Previous studies indicate HIV positive men prefer a GUM service within their HIV centre. This new service was introduced to reflect this finding. During this review the service was well utilised, the high rates of infection reflect a continuing need for this service.

## PA2

## The epidemiology, clinical features, and diagnosis of women with trichomoniasis in a south London sexual health clinic: 2003–2004

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**Aims:** To determine the clinical presentation and management of female genitourinary medicine clinic attendees with *Trichomonas vaginalis* infection.

**Methods:** A retrospective case notes review was undertaken of all cases of *T. vaginalis* infection diagnosed in females in a 12 month period between January 2003 and December 2003 (n=155). Descriptive features of these patients were collated.

**Results:** The incidence of *T. vaginalis* infection was 3.0% in 2003. The mean age of patients was 28.8 years. Black Caribbean and Black African women were over-represented. Overall, patients were more likely to be symptomatic at presentation (78.1%) and have vaginal discharge as their presenting symptom (87%). 19% had co-existing chlamydia infection and 7% had co-existing gonorrhoea infection. There were 2 new HIV diagnoses. Culture improved diagnosis, identifying an additional 10% of cases. Contact tracing was initiated in 81.3% of cases. There was one 'true' treatment failure.

**Conclusions:** The mean age of 28.8 years is lower than that quoted in other studies. Most patients were symptomatic at presentation. The rate of co-infection with chlamydia was high, we should consider giving empirical treatment for chlamydia in patients diagnosed with *T. vaginalis* infection. Routine test of cure could be stopped.

## PA3

## Review of cases referred to genitourinary medicine by community paediatrics/forensic medical examiner

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**Introduction:** This department has a dedicated clinic (SA) for adult victims of sexual assault for STI screening but STI screening in children has traditionally been undertaken on an ad-hoc basis. Links with local Forensic Medical Examiners (FME) and Community Paediatricians (CP) have been strengthened to facilitate referral of younger patients for appropriate screening. Pre-pubertal children, usually with chronic rather than acute sexual abuse, were seen at the SCAN (suspected child abuse and neglect) clinic run by CP, in a co-ordinated 'one-stop shop' approach, with FME, video-colposcopy and STI screening. Post-pubertal youngsters, particularly those disclosing an acute assault, were seen in the SA clinic, having already had a two doctor forensic medical examination. The case load for CP/FME referrals from 1/4/03–31/3/04 was reviewed by retrospective case record examination.

**Results:** Nineteen (5 boys, 14 girls) were referred. Eight (4 boys) aged 1–13 were seen at SCAN. Eleven (one boy) aged 12–14 were seen at SA. Two girls (1 and 3) had vulval erythema and genital warts respectively with no suggestion of abuse. Fifteen (4 boys) alleged non-consensual sexual intercourse (SI) in whom no STI were detected.

**Conclusion:** Awareness of STI risk in SCAN patients allows co-ordinated and comprehensive examination and appropriate screening.

## PA4

## Audit of child protection issues in under 15 year olds attending a department of genitourinary medicine

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**Introduction:** More young people under the age of 16 years are sexually active, with consequent child protection issues. This department's policy is for all attendees under 16 to be seen by a Health Adviser (HA) to highlight any child protection concerns. This was audited by retrospective case-note review for those aged <15 years, attending 1/4/03–31/3/04.

**Results:** Thirty-six people aged <15 were seen; 6/36 were excluded (not sexually active). Eleven, (one boy, 10 girls) aged 12–14, were seen at the dedicated sexual assault clinic; all were referred by the police with child protection team (CPT) involvement. Nineteen (2 boys, 17 girls) were seen at routine clinics: one girl aged 13, 18/19 aged 14. Two girls reported non-consensual sexual intercourse (SI) when drunk. Of 17 (15 girls) admitting consensual SI, partners were aged <16 in 12, 16–17 in 3, 22 in one and unknown in one. HA saw 16/19 attending routine clinics; 3/19 were already known to CPT. A responsible adult (carer/parent) was identified in 11/19; of the seven admitting consensual SI without an identified responsible adult, all had partners <16; all were deemed Fraser competent.

**Conclusion:** No cases of un-addressed child protection concerns were identified in patients aged <15 years.

## PA5

### Kaposi's sarcoma progressing during pregnancy – lack of suppression by hCG

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**Background:** HIV associated KS is rarer in women. The pregnancy associated hormone human chorionic gonadotropin (hCG) induces apoptosis of HIV associated KS cells *in vitro* and in mouse xenograft models.

**Methods:** Since 1986 1137 HIV+ patients have been diagnosed with KS including 18 women (1 gender reassignment). Two presented during pregnancy. The clinicopathological features and clinical course of these patients were examined.

**Results:** The clinical features are shown and in both cases there was a disease progression during the third trimester. Following delivery one woman had spontaneous regression of disease whilst another required radiotherapy.

Age	Gestation	Stage	Biopsy	CD4 (mm <sup>3</sup> )	VL (copies/ml)	Sites
32y	36-40	T1 G3B	Nodular	235	70	Cervical node
30y	24-40	T1 G3B	Plaques	830	<50	Skin

**Conclusions:** We report two cases of KS presenting and progressing during pregnancy when hCG levels are extremely high. This contradicts two previously reported cases where spontaneous remissions of KS during pregnancy were observed. Moreover this observation contradicts the laboratory findings of KS response to hCG.

## PA7

### Reception triage in the HIV emergency clinic

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**Background:** HIV patients were attending the HIV Emergency Clinic with issues that could be appropriately dealt by someone other than the doctor. Alteration in this service could potentially improve care if patients were seen by appropriate staff.

**Aim:** To assess the appropriate use of walk in clinics.

**Method:** We audited attendances over 1 week prospectively. Data collected included reason for attendance, if considered appropriate and who else could have dealt with the problem. Data was re-audited after 5 months.

**Results:** Only 45% attendances were deemed appropriate and 41% patients could have been dealt by other members of staff. A questionnaire was developed for use at reception to help redirect individuals walking in to appropriate members of staff or outside agencies. In addition posters and leaflets were produced to advise patients of the appropriate use of the emergency clinic. On re-auditing, 54% attendances to the clinic were deemed appropriate and only 18% of patients could have been dealt with by someone other than the doctor.

**Conclusion:** Reception triage has been helpful in improving the appropriate use of the HIV emergency service. Further work is planned to develop nurse triage and encourage increased use of GP services.

## PA6

### Switching to once daily antiretroviral therapy

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**Aim:** To assess the uptake of the offer of once daily HAART on patients already established on HAART.

**Methods:** A retrospective analysis of 78 consecutive individuals who had been assessed for once daily therapy.

**Results:** 33 individuals were not offered the switch: 22 because of the inability to construct an o.d. regimen, 4 due to pregnancy and 11 due to other clinical reasons. 45 individuals were offered a switch to once daily HAART of whom 35 (78%) accepted. Of the 10 who declined 4 (40%) were afraid of the consequences and the other 6 (60%) were happy with their current regimen. 10/35 (29%) switched for clinical reasons on the advice of the clinician. The reasons given by the other patients for accepting a switch were: increased convenience (9, 26%) and reduced pill burden (17, 49%). The patients who switched for non-clinical reasons had previously received 1–11 (median 3) regimens. The commonest nucleoside backbones were abacavir/3TC (8, 23%) and tenofovir/3TC (6, 17%). Nevirapine (15, 43%), boosted Atazanavir (10, 29%) and efavirenz (8, 23%) were the commonest third agents.

**Conclusion:** A high proportion of patients who are suitable for o.d. therapy will decide to change if offered the choice.

## PA8

### Hypertrophic herpes simplex genitalis in HIV-1 infection

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**Aim:** Description of 3 cases of Hypertrophic Herpes Simplex Genitalis [HSV] in HIV 1 infected patients.

**Cases:** One 30yo Congolese man. 3-year history of HIV, on antiretroviral therapy [ART], viral load [VL] <50cpm, CD4 >400 × 10<sup>6</sup>/l. Recurrent genital ulceration despite Valacyclovir prophylaxis. He developed multiple disfiguring hypertrophic lesions of the penis and perineum. No response to Foscarnet or Cidofovir. TK mutation negative. Excellent response to Thalidomide/ Valacyclovir combination.

2: 48 year old Rwandan woman. 7-year diagnosis of HIV, VL<50cpm on ART. CD4 count <200 × 10<sup>6</sup>/l. Dapsone as PCP prophylaxis. Recurrent HSV 2 initially responded to episodic Valacyclovir, but progressed to hypertrophic lesions. No response to Cidofovir; relapse within weeks of Foscarnet. Trials of Valgancyclovir and Thalidomide unsuccessful. Histology at vulvectomy: VIN 3

3: 34-year-old Ugandan woman. 2-year diagnosis of HIV, on ART with a CD4 > 500 × 10<sup>6</sup>/l. Genital ulceration treated episodically with Valacyclovir; culture negative. Developed hypertrophic labial and perineal lesions.

**Histology:** Marked lymphocytic, plasmacytic and eosinophilic infiltrates and immunohistochemistry positive for HSV.

**Discussion:** Hypertrophic HSV is unusual, even in the setting of HIV [3/1200 in our cohort, all African], difficult to treat, and may predispose to dysplastic changes.

## PA9

Acceptability of the role of Advanced Nurse Practitioner (Sexual Health): A comparison study with the Senior House Officer (SHO) on patients attending for sexual health screening in the Genito-Urinary and Infectious Diseases Clinic (GUIDE), St James Hospital, Dublin

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**Background:** The role of the Advanced Nurse Practitioner (Sexual Health) was initially proposed and developed in 1997 following the increasing incidence of sexually transmitted infections (STI's) both locally and nationally.

**Aim:** The aim of this study is to demonstrate that patients are receiving equally satisfactory care from the ANP (Sexual Health) as they are from the SHO.

**Methodology:** A quantitative approach was employed, by administering an anonymous questionnaire, designed to measure the satisfaction with the service.

**Results:** Overall 90% response rate, 97% from patients seen by the ANP and 83% from patients seen by the SHO. Results were favourable from both groups. Higher scores measuring information given to patients on 'what to do should difficulties with treatment arise', ANP (76%) and SHO (60%), and on what to do 'should a recurrence of problem occur' ANP (81%) and SHO (57%), were seen in the ANP group. A higher number of patients were referred to the Health Advisor and Counsellor by the SHO, demonstrating the breadth of the professional remit of the ANP.

**Conclusion:** In this sexual health clinic, the investigation has shown that patients are equally satisfied with the care provided by the ANP as they are with that offered by the SHO.

## PA10

A review of service delivery in a community-based HIV service: 1989-2004

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The HIV service started in a community based Genitourinary Medicine (GUM) setting in 1988 becoming part of an holistic Sexual Health Service in 1993. There have been major changes in the epidemiology of the cohort (586) over 15 years. Responsive to patients' needs, audits of practice were carried out leading to specific service developments. HIV sexual health clinics were established focussing on pre-conceptual counselling, contraception, cytology and STI screening. Increased recruitment of women required the development of a Family clinic, an antenatal clinic and a postnatal clinic, facilitated by the availability of clinicians working within the integrated service. The full range of antiretroviral therapies, resistance testing and therapeutic drug monitoring was available. Treatment outcome audits showed equivalence to figures from clinics within teaching hospital or DGH settings. Close collaboration from the local DGH, three miles distant, led to the development of paediatric and obstetric protocols. Antenatal testing (96%) and the prevention of vertical transmission (0/40) have been very successful. There has been less success in providing robust in-patient medical management.

**Conclusion:** This review shows that the vast majority of HIV care can be provided from such a community base should clinicians with the interest and skills wish to develop it.

## PA11

Recurrent cryptococcal meningitis in a HIV positive man despite HAART and induction/maintenance therapy. Can CD4 counts mislead?

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A 55 year old HIV positive Caucasian man was admitted in July 2002 with increasing headache, nausea and vomiting. CD4 count 280 cells/mm<sup>3</sup>, on HAART (Trizivir) and viral load undetectable. He had cranial nerve palsies and a small midbrain lesion on CT scanning. Blood cultures identified *Cryptococcus neoformans* var. *neoformans*. Therapy: 2 weeks of I.V. AmBisome and Flucytosine. He had worsening visual acuity. CT Brain showed ventricular dilatation and opening pressure on lumbar puncture was 46cms/H<sub>2</sub>O, therefore a ventriculoperitoneal shunt was inserted. CSF culture was negative for fungal growth. He was discharged on Fluconazole 400mg. In October 2002 he was readmitted with recurrent symptoms despite treatment adherence. CD4 count 100 cells/mm<sup>3</sup>, CSF was positive for *Cryptococcus* Ag and culture. He received induction and maintenance therapy as before, CSF samples at 2 and 4 weeks were clear. In July 2004 he presented with arm weakness, confusion and seizures. CD4 count 200 cells/mm<sup>3</sup>, Serum and CSF cryptococcal Ag positive, MRI Brain showed focal lesions. Therapy: I.V. AmBisome for 3 weeks (with marked clinical improvement). On discharge CSF Ag titre 1:2, culture negative and continued maintenance therapy of Fluconazole 400mg. He remains well with quarterly CSF surveillance. Interestingly viral loads were undetectable throughout.

## PA12

HIV-associated pulmonary arterial hypertension (PAH)

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A 44-year-old Caucasian woman with no prior history of cardio-respiratory disease presented in March '04 with increasing dyspnoea, dry cough and lethargy. Her oxygen saturation was normal but she was tachypnoeic and had a loud P2 and pan-systolic murmur. A V/Q scan, high-resolution CT scan, CT pulmonary arteriogram and Echo showed elevated right ventricular systolic pressure (RVSP=85mmHg) and a dilated right ventricle (end-diastolic diameter RVEDD=47mm). Cardiac catheterisation confirmed PAH. Epoprostenol (prostacyclin analogue) infusion during the procedure produced no significant fall in pulmonary arterial pressure. On six-minute walk testing she covered 93m with no desaturation. Her husband originated from Zimbabwe, therefore both were tested and found to be HIV-positive. Her baseline CD4 180 cells/mm<sup>3</sup> with viral load 7,900 copies/ml. She commenced HAART (Combivir and Efavirenz) and Bosentan (endothelin receptor antagonist) at 62.5mg bd for 4 weeks, 125mg bd thereafter with monthly LFT checks and TDM for Efavirenz.

On repeat six-min walk testing at 2 months she covered 186m with no desaturation. Most recent Echo revealed a RVSP 61mmHg, RVEDD 43 mm. This case illustrates that combination treatment with HAART and Bosentan may significantly improve functional and haemodynamic parameters in a disease previously considered to have a uniformly poor prognosis.

## PA13

### Diagnosing hepatitis C (HCV): an opportunity lost?

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**Aim:** To see if unsuspected cases of HCV are missed in a G-U Medicine clinic in a District General Hospital.

**Method:** HCV tests were offered to all New Episode (New=N and Rebook=R) patients, opting for an HIV test. (01/01/2004–31/03/2004).

Previously, HCV tests were offered only to patients with a 'risk' history, (injecting drug use, HIV positive etc.). Initial test, ELISA antibody (a/b) (ortho eci on vitros). Confirmation, ELISA a/b (biorad). RNA, PCR (artus).

**Results:** Total New Episodes=1622. (N=845+R=777). Total HIV tests, (S2+P1A)=833; HIV offered, (P1B)=489. Total HCV tests=700. Initial test: 14 non-negative=7 reactive+7 intermediate. (None HIV positive). **Confirmation:** 7 reactive=5 positives+1 intermediate+1 negative; 7 intermediates=7 negatives.

**RNA:** Of 5 a/b positives; RNA=3 positives+2 negatives; (a/b intermediate & a/b negative=RNA negative). HIV positives:=3 (All negative HCV). 5 patients = Hepatitis C positive. All 5 had given 'risk' history. 1= 'possible HCV' (No 'risk' history). (All 6 referred Gastroenterology.)

8 = 'HCV Negative' (No 'risk' history); advised.

**Conclusions:** In this clinic, no definite cases of HCV, would have been missed if tests were offered only to patients with 'risk' history. A patient's history is an excellent guide to risk of HCV.

**References:**

Hepatitis C Strategy for England, Department of Health, August 2002. Wankowska, H. A Year in Prison, Poster Presentation, BASHH, Bath, 2004.

## PA15

### Audit of sexually transmitted infections (STI), Hepatitis B (HBV) and Hepatitis C (HCV) monitoring in HIV positive patients

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**Aim:** To monitor STI & HBV/HCV status in all the HIV positive patients attending GUM clinic in Nottingham between September 2003 and October 2004.

**Audit standard:** All HIV positive patients should be offered sexual health screen yearly and HBV/HCV status identified and vaccinated as appropriate.

**Methods:** Retrospective case note audit was performed. Demographic, epidemiological and clinical data were collected.

**Results:** 100 case notes analysed. 49% patients had STI screen in the last one year and among them 49% had at least one STD diagnosed. Syphilis testing was done in 54%.

The reasons for no STI screen: 37% not offered; 29% not sexually active; 22% not indicated. HBV status assessed in 91%, 44% were susceptible but only 15% were vaccinated. 75% were screened for HCV, 9% had HCV coinfection.

**Conclusion:** We are not achieving the standard for STI screening in sexually active HIV+ patients. In patients who were screened a significant proportion of STI were identified. Although majority were screened for HBV/HCV, a significant proportion of them were not appropriately vaccinated. STI screen must be offered at least once a year and HBV vaccination should be offered in those who are susceptible.

## PA14

### Audit of virological and immunological outcome of a patient group on treatment with Tenofovir (TDF) and didanosine (ddI) plus Efavirenz (EFV) or Nevirapine (NVP)

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**Aim:** To audit efficacy of ddI+ TDF + EFV/NVP-containing regimes in clinic population following reports of suboptimal CD4 and Viral load (VL) responses in HIV infected individuals.

**Methods:** Clinical audit of individuals identified on the above regimes.

**Results:** 12 individuals identified: 8 male, 4 female. Median age: 41.5 years (32–70). 10 received EFV, 2 NVP. 3 groups: 3 were naïve, 9 had received prior HAART: 5/9 had been switched for lipodystrophy (S), 4/9 started on this regime after a treatment interruption (TI). Median time on therapy: 9.5 months (2–33). Median baseline VL: 2425 copies/ml (<50–136,000). Median baseline CD4 count: 257 cells/mm<sup>3</sup> (38–529). At 3 months 10 were suppressed on treatment. 2 experienced virological failure: 1 naïve and 1 TI. The naïve patient had mutations: 211K 98S 135T 179D 190C 190S. At 6 months (n=8) all remained suppressed. At 9 months (n=6) 5 remained suppressed. At 12 months (n=3) all remained suppressed. At 15 months another (S) had virological failure. Median CD4 count increase (? CD4) at 3 months was 40 (–786–419) and at 6 months was 32.5 (–281–388).

**Conclusion:** 3 individuals on ddI+ TDF + EFV/NVP-containing regimes experienced virological failure and the ? CD4 was small.

