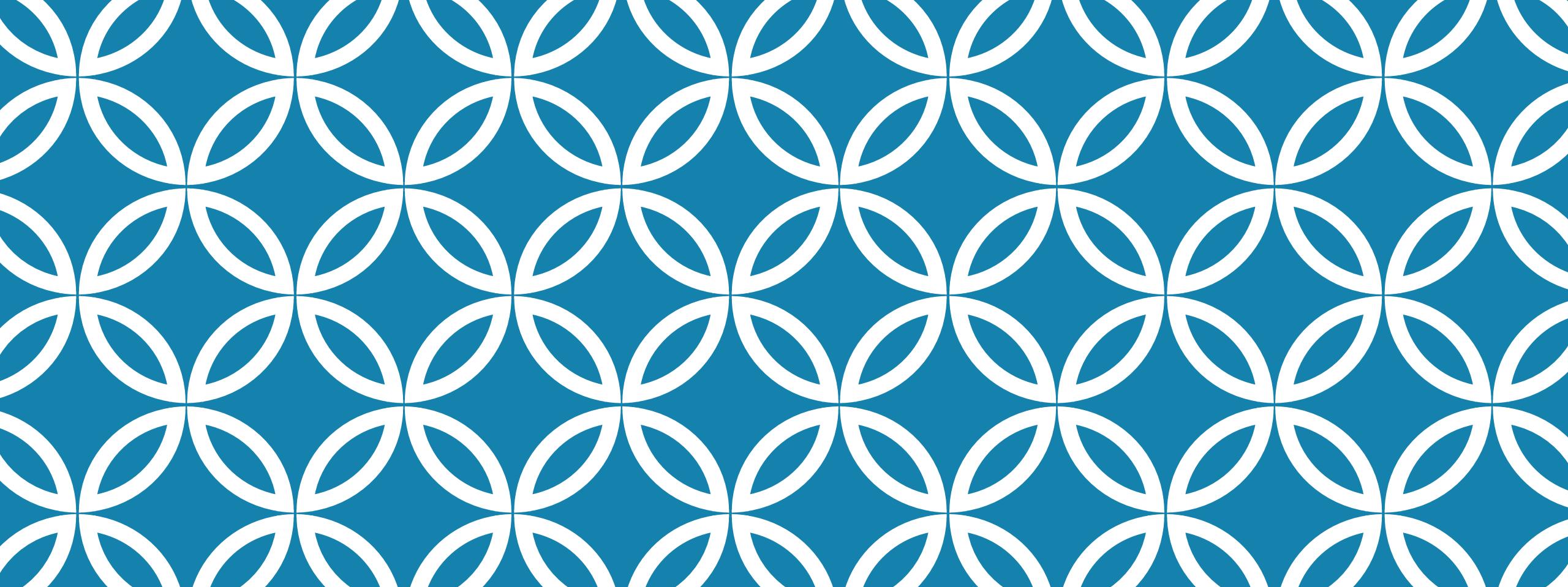




21st Annual Conference of the National HIV Nurses Association (NHIVNA)

27–28 June 2019 · Manchester Conference Centre



**WHO RUNS THIS
MOTHER F*** WORLD**

Stewart Attridge
HIV ANP
Cardiff Royal Infirmary
Cardiff & Vale UHB

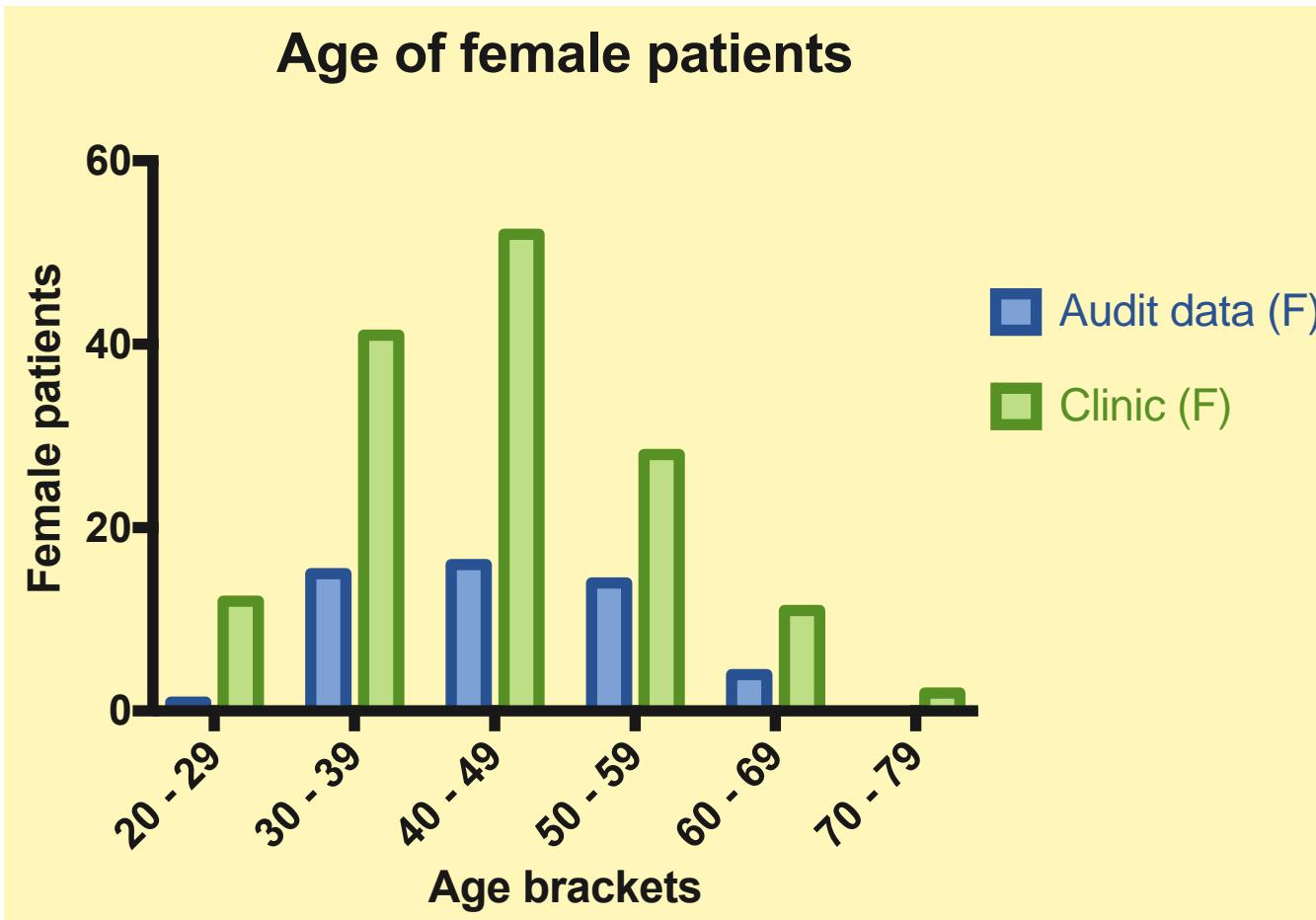
CONTENTS

- ♀ CRI cohort
- ♀ Female appointments
- ♀ Lifestyle factors
- ♀ PMH
- ♀ ARVs & Switches
- ♀ Contraception
- ♀ Menopause
- ♀ Cytology

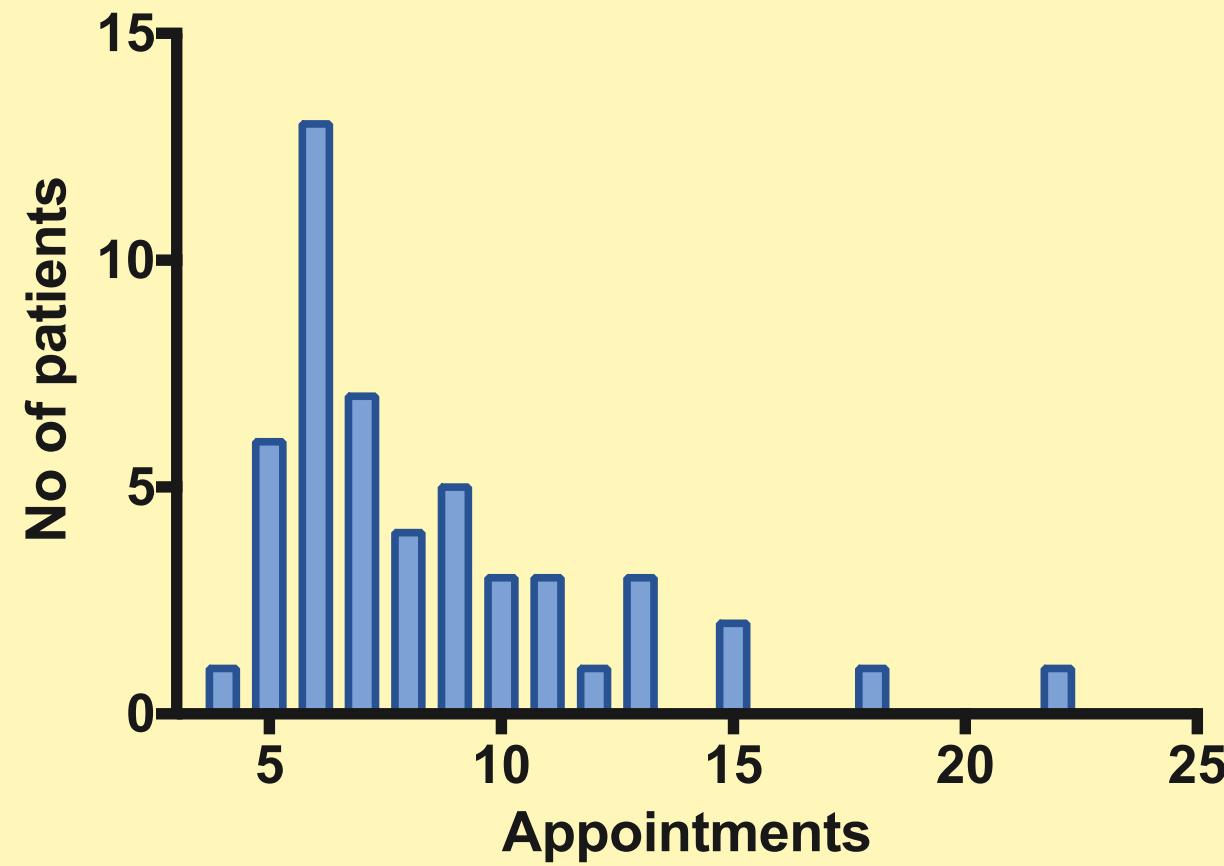
**Review of Clinical notes
2016 - 2018**



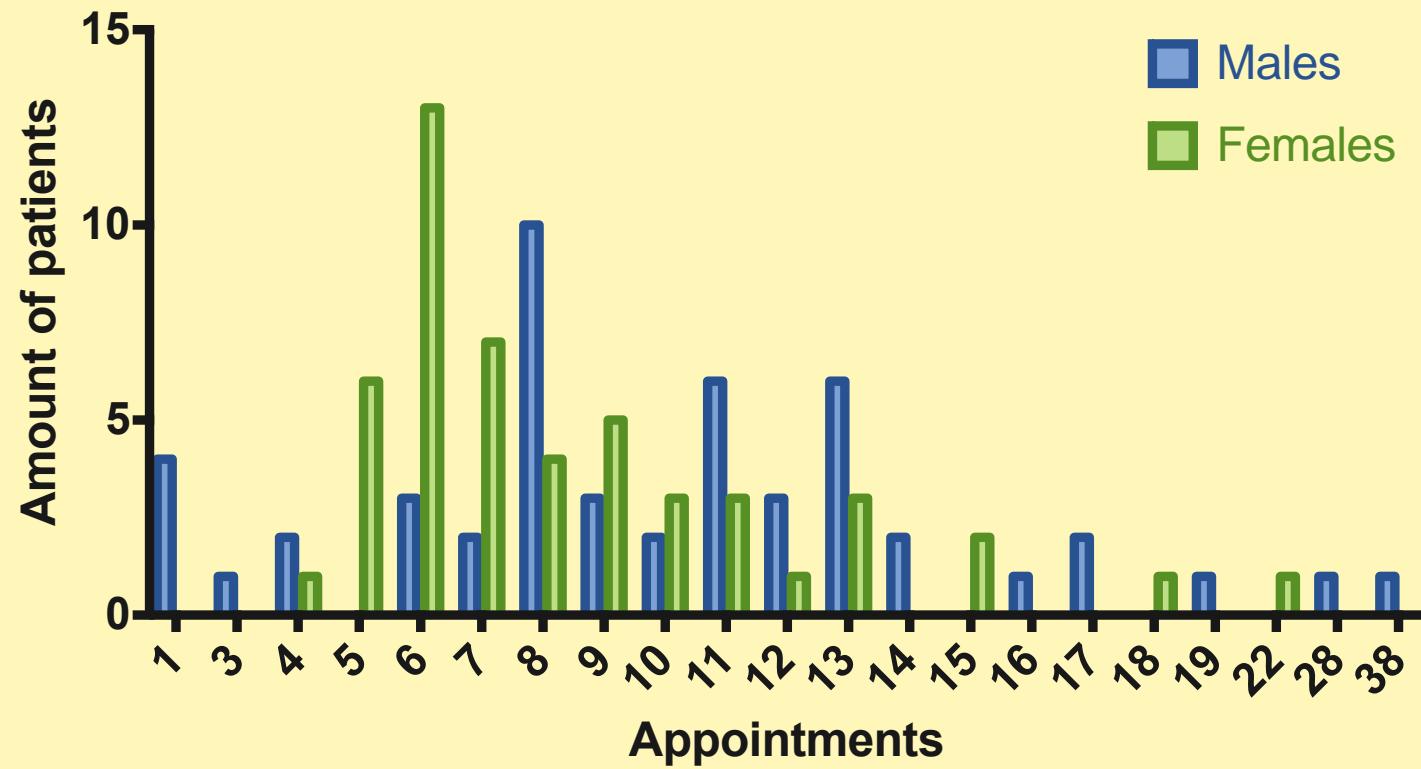
AUDIT DATA



Female appointments 2016 - 2018



Appointments 2016 - 2018

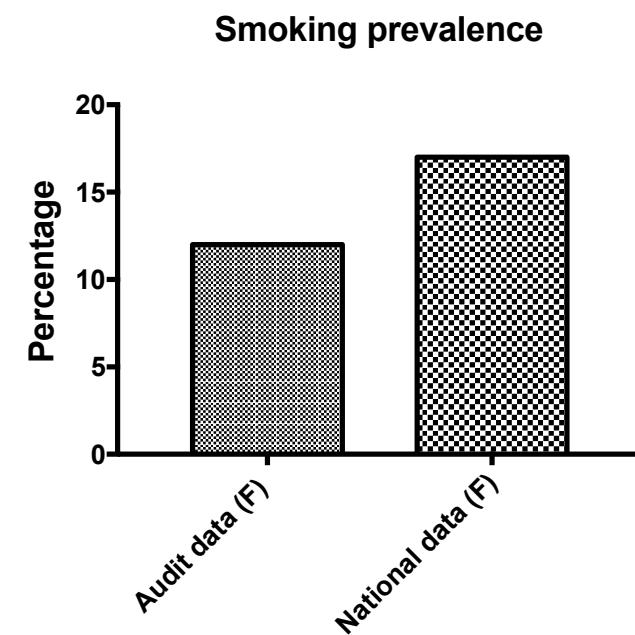
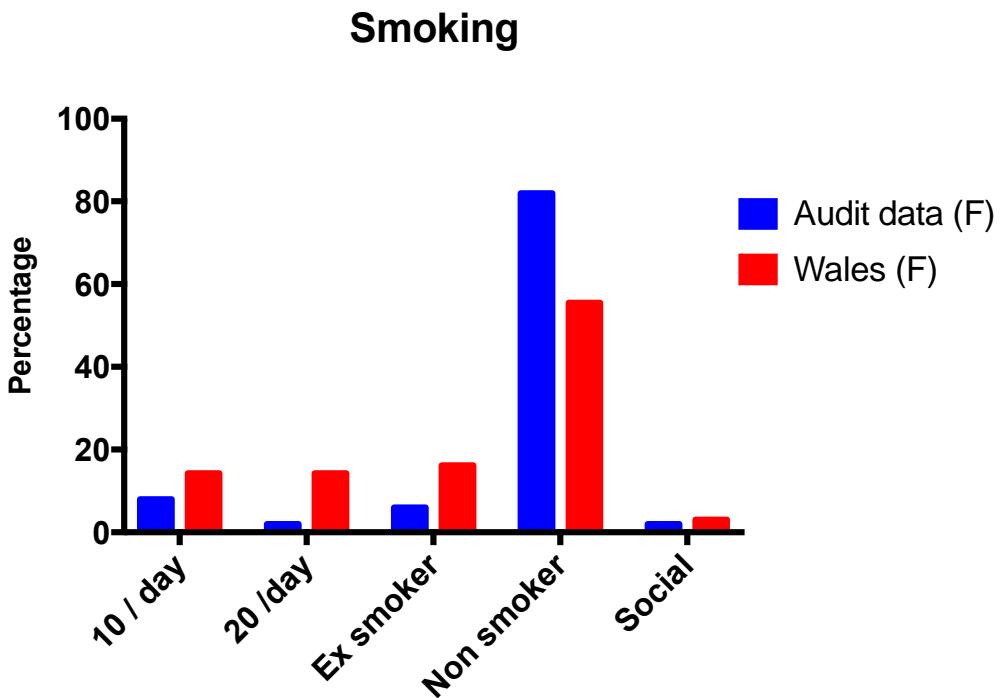


Appointments	Males	M(%)	Females	F (%)
1 to 6	10	20	20	40
7 to 10	17	34	19	38
11 to 16	18	36	9	18
17 to 38	5	10	2	4

SMOKING

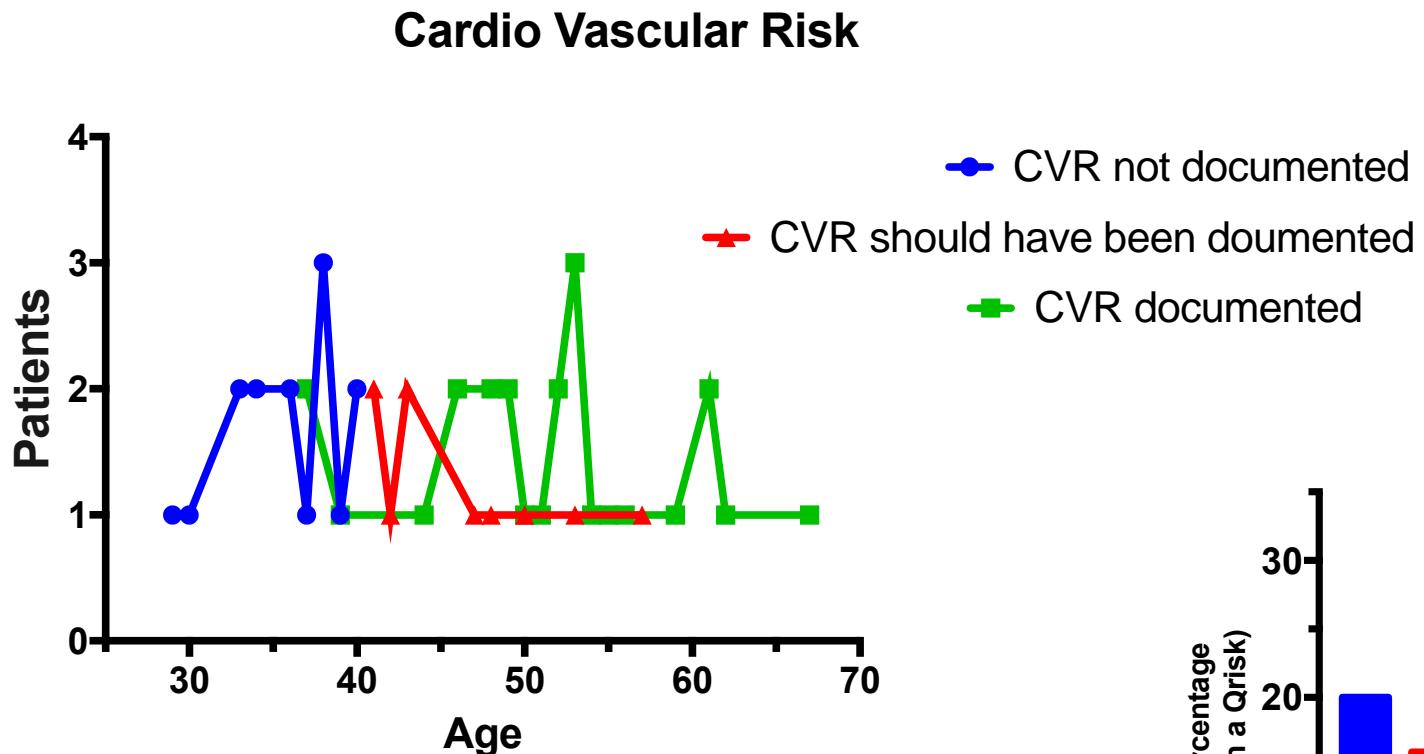
Comorbidities

- Proportion of people living with HIV with a smoking history documented in the last 2 years (target: 95%) and blood pressure recorded in the last 15 months (target: 95%).
BHIVA Standards of Care 2018



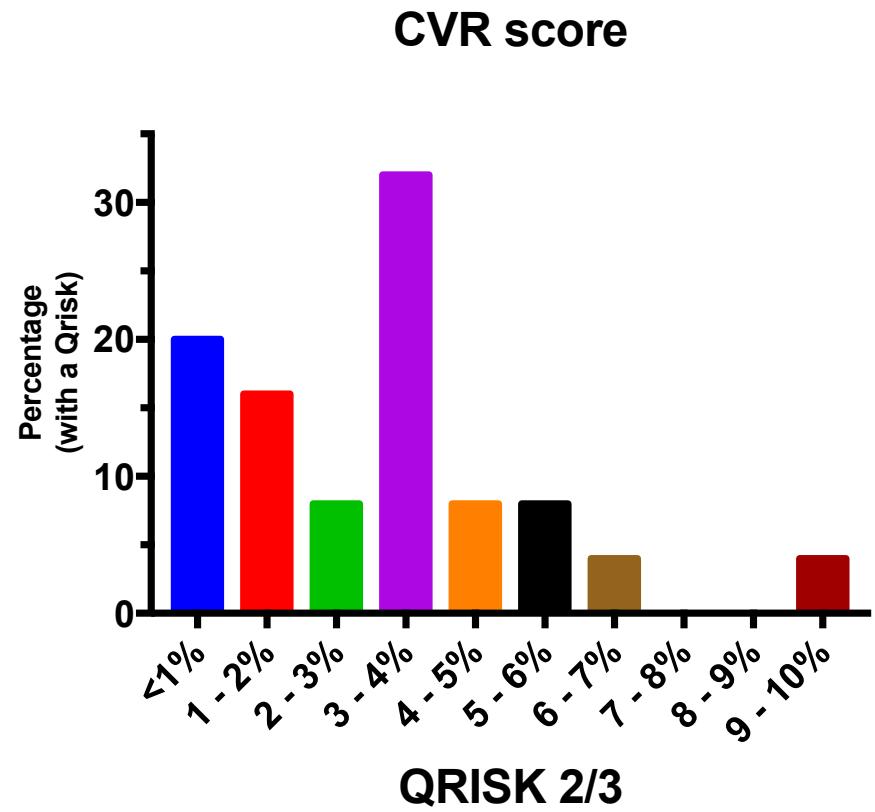
CARDIO VASCULAR DISEASE

- Cardiovascular risk assessment for patients >40 years old (QRISK2)



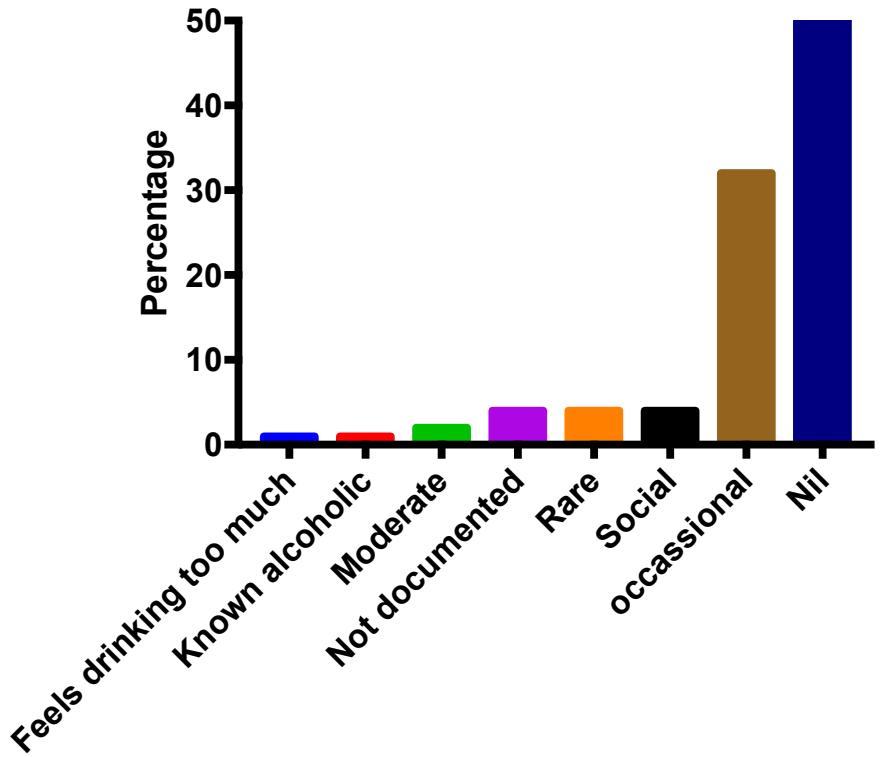
CVR not documented in 50% of patients

- Not documented for 5 (out of 6) smokers
- Not documented for 2 (out of 3) smokers

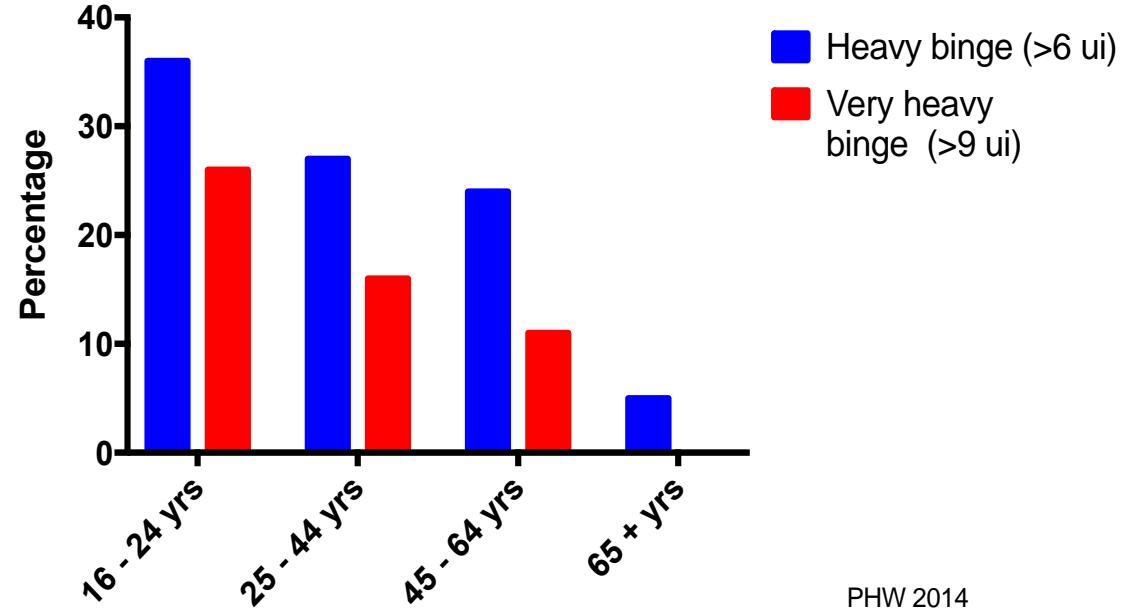


SUBSTANCE MISUSE

Alcohol consumption



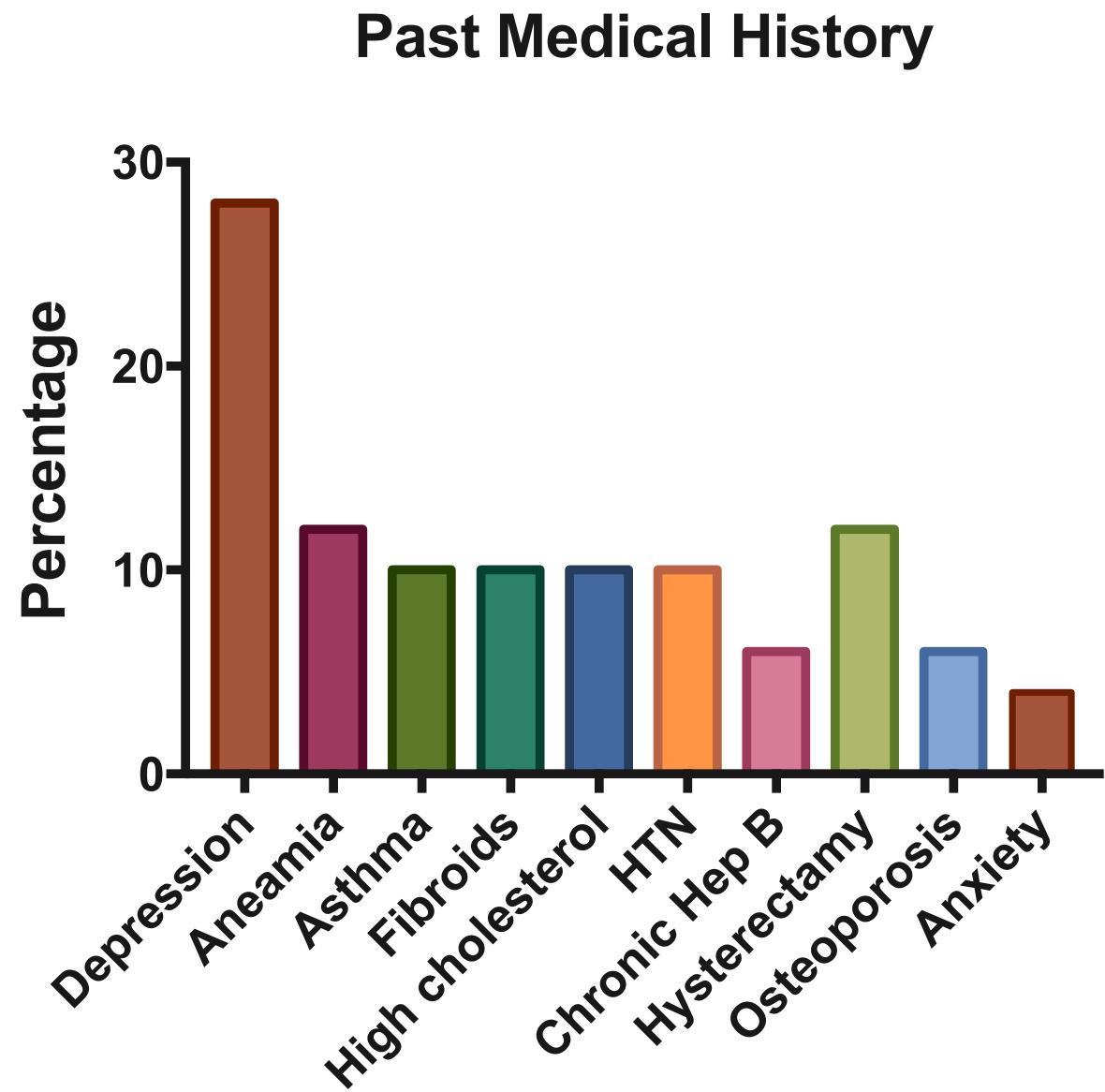
Alcohol consumption by Cardiffian Females



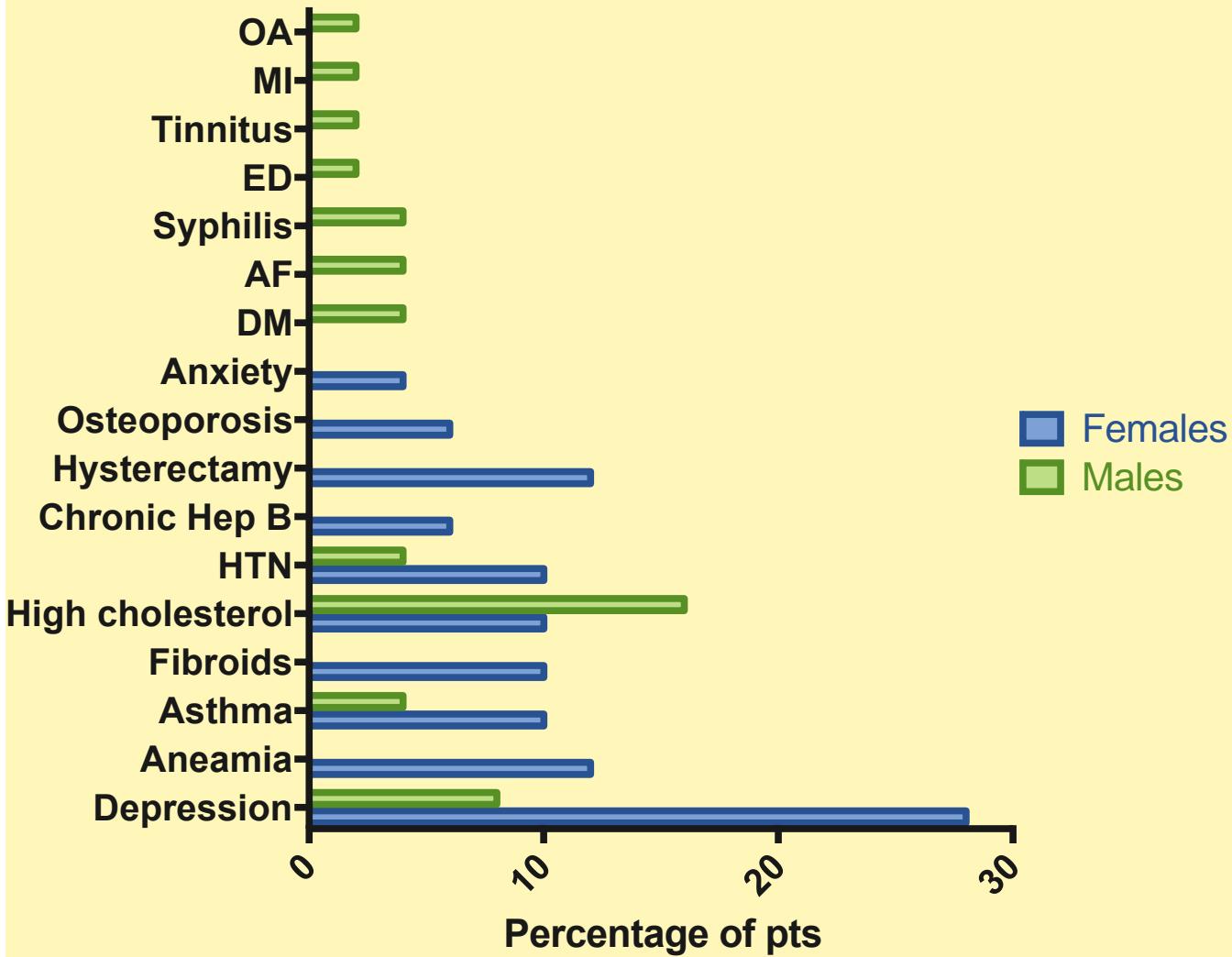
PHW 2014

Recreational drugs	No of patients
Nil	1
Smokes crack	1
Not documented	2
Nil	46
Grand Total	50

PAST MEDICAL HISTORY

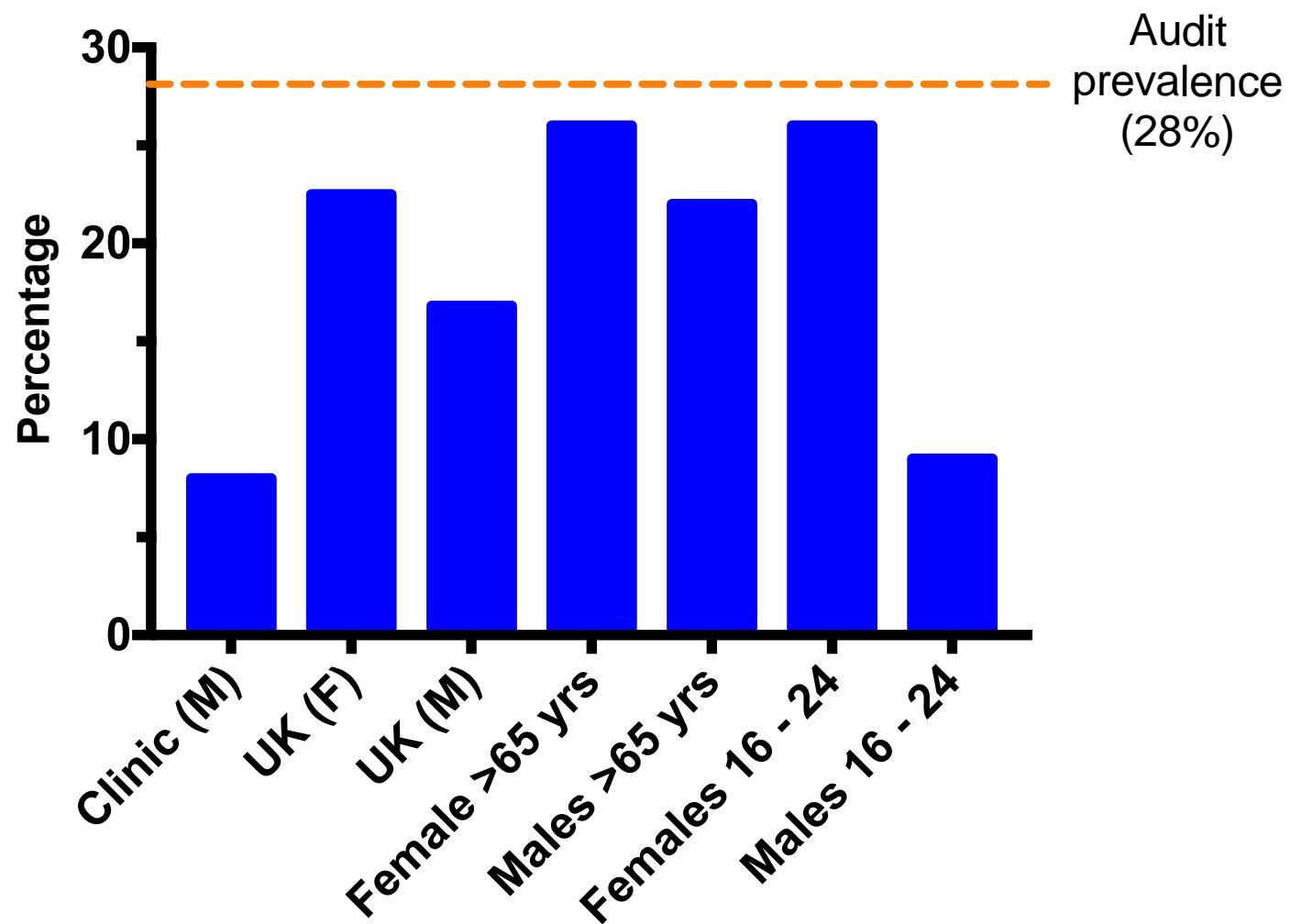


Past Medical History



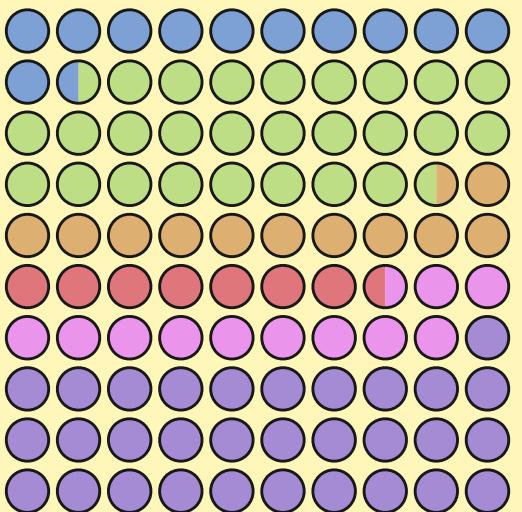
DEPRESSION

Depression rates

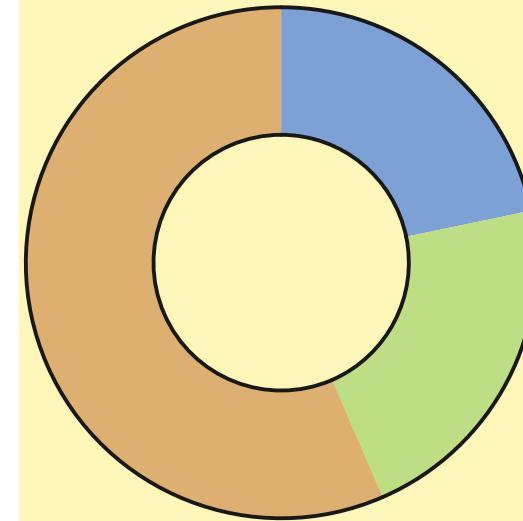


ARVS

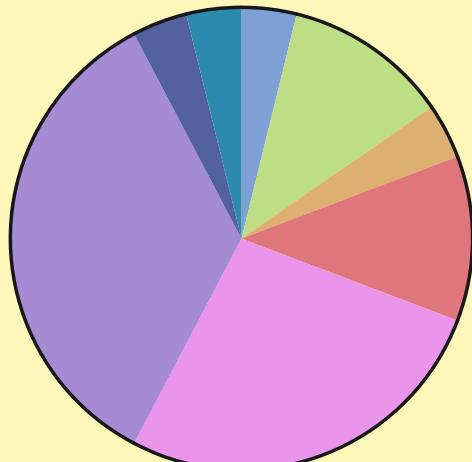
ARVs - Single Tablet Regimes



ARVs - NRTIs

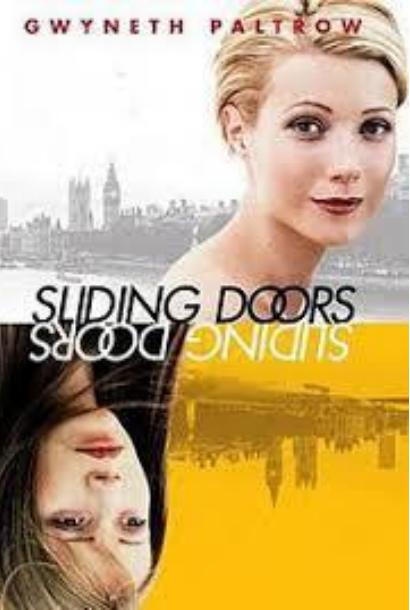


NNRTIs / PIs / Integrase

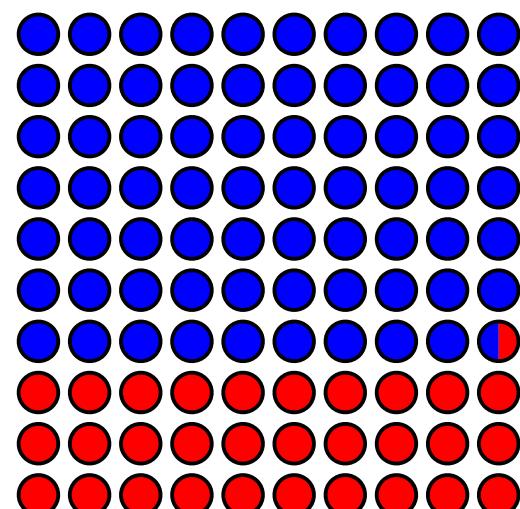


SWITCHES

Switches	Pts
Integrase to Integrase	1
TRV - Kivexa	1
Integrase to NNRTI	1
NNRTIs to NNRTI	1
PI/r to Integrase	2
NNRTI to PI	2
Kivexa - F/TAF	3
TDF - TAF	4
NNRTI to Integrase	5
PI/r to PI/c	9
Grand Total	29



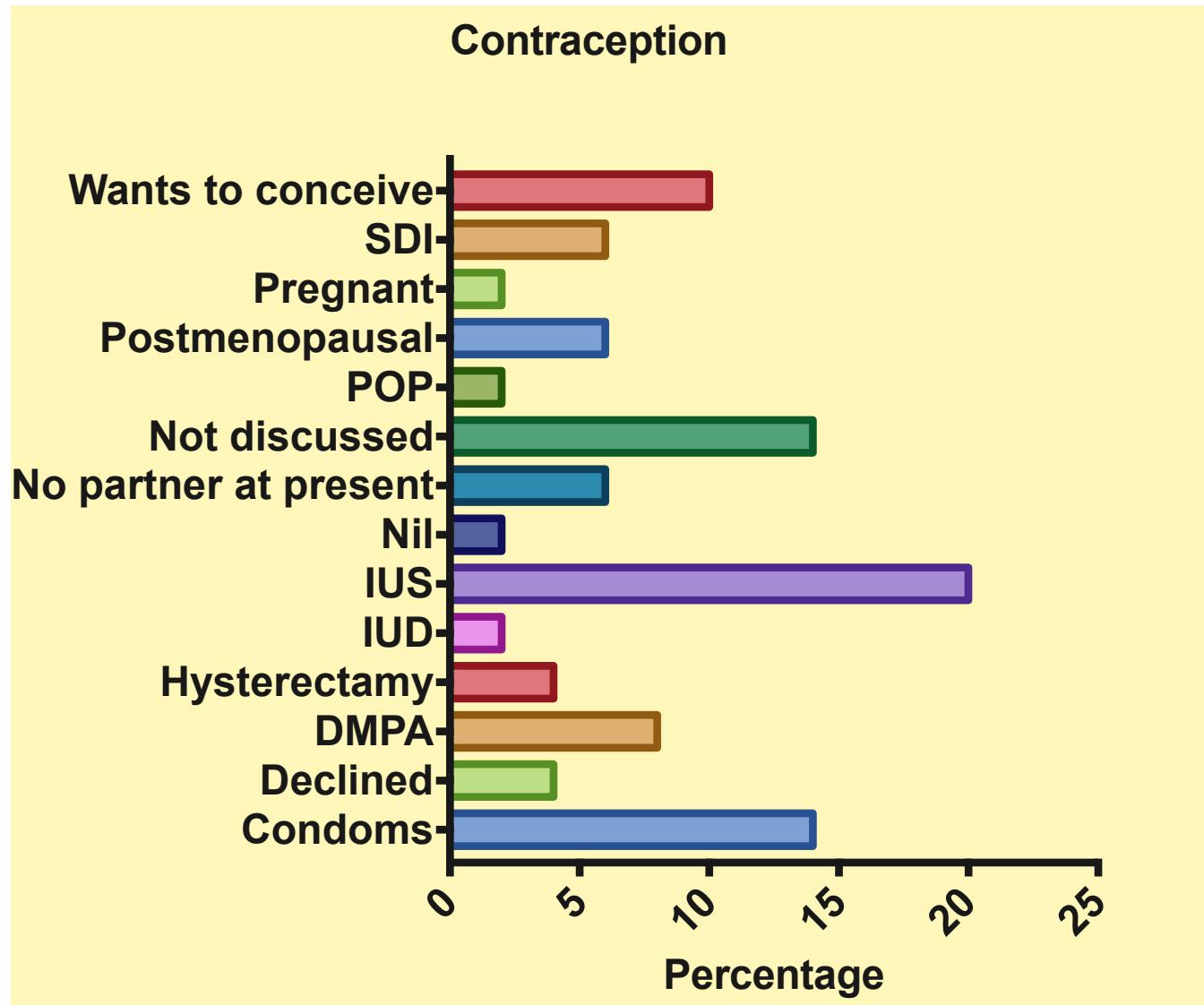
Number of switches



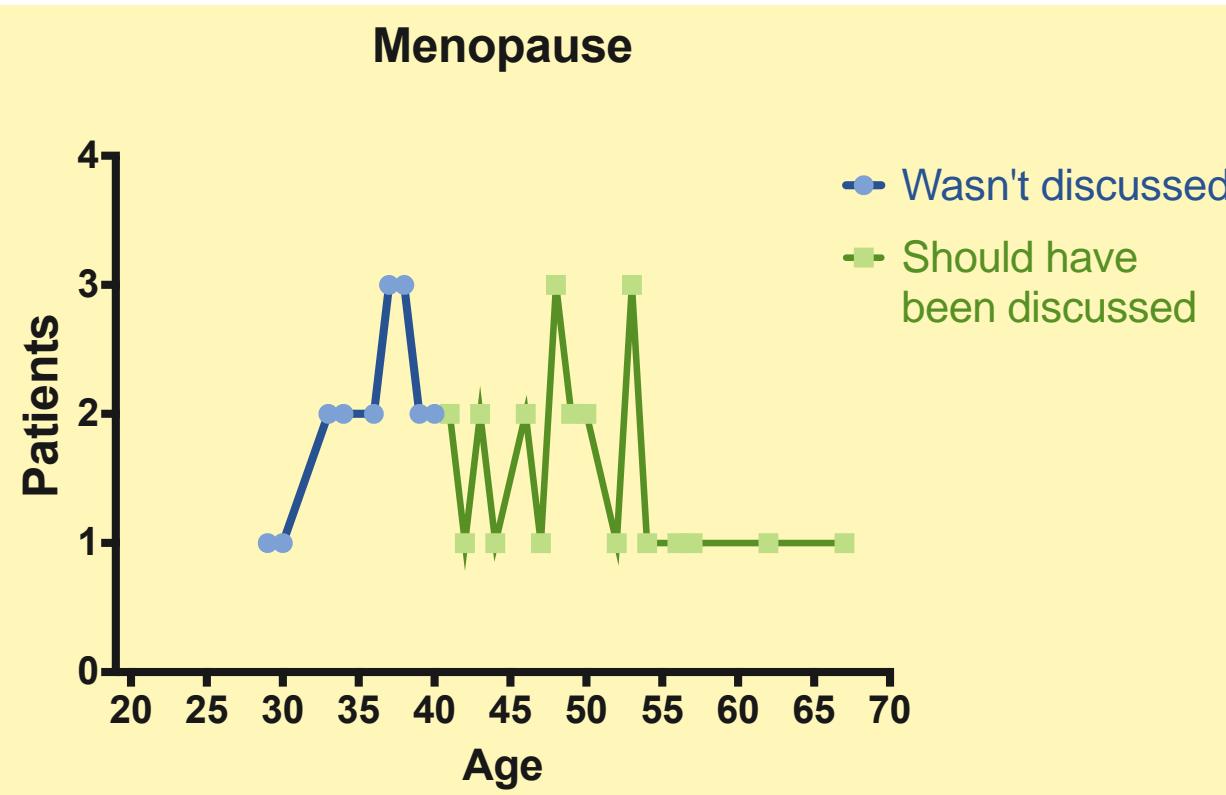
■ 1 Switch (N=23)
■ 2 Switches (N=10)

CONTRACEPTION

Contraception not discussed	
Age	No of patients
37	1
50	1
52	1
54	1
55	1
56	1
61	1
62	1
67	1
Grand Total	9



MENOPAUSE



NICE guidance:-

No need for FSH if >45yrs:-

- Vasomotor symptoms & irregular menses = Perimenopausal
- No menses for 12 months (no contraception) = Menopausal

FSH tests <45 yrs. - 2 elevated tests 6 wks apart – ok with Progesterone only, but not Combined

- Menopausal symptoms (inc menstrual symptoms)

Vasomotor

- Hot flushes, sweats

Musculoskeletal

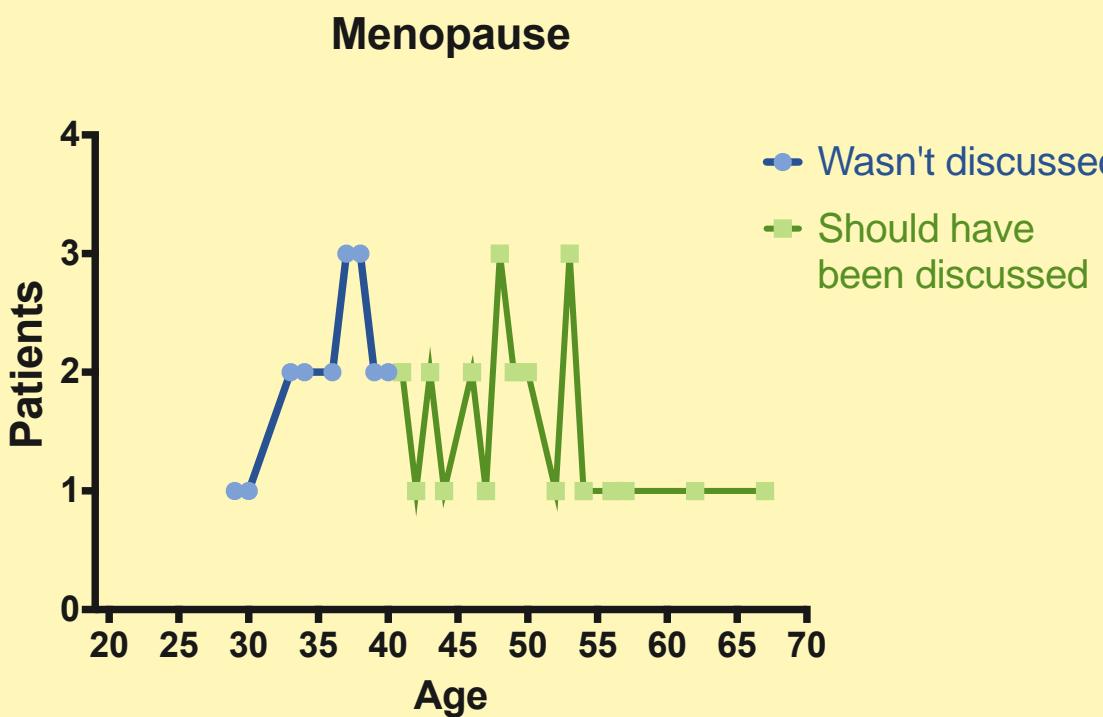
- Joint & muscular pain

Mood

- Depression
- Low libido

Urogenital

- Vaginal dryness



Nottingham University Hospitals NHS Trust SEXUAL HEALTH

Quality Improvement Project

J. Lunatsi, M. Pammi, S. Chadwick, D. Gamoudi, K. ...

Background

In 2016, 10,350 women living with HIV aged 45-56 attended HIV clinics in the UK. The BHIVA/BASHH/FSRH Guidelines for sexual and reproductive health (2017) state that all women between the ages 45-56 should have an annual menopausal review and be given information about the perimenopause/menopause along with information around the use of HRT.

Aim

Approximately 13% (153/1200) of our HIV cohort are women aged between 45-56. Our aim was to review these women attending our services and assess if they have ever discussed menopause, have menopausal symptoms and whether they might benefit from a discussion about or initiating HRT.

Methods

A comprehensive questionnaire looking at contraception, menopausal symptoms, comorbidities, medications and lifestyle risk factors was developed and information obtained.

Case note review was undertaken following completion of the questionnaire and information gathered around clinical review. FRAX and cardiovascular scores were calculated and their antiretroviral (ARV) regimen were reviewed.

Results

- 31 women between age 45-56 completed the questionnaire. 90% of these women are on HIV treatment and all had an undetectable viral load.
- 81% were Black African/Black Caribbean, 13% White British and 6% Asian in Ethnicity. (Chart 1)
- None of them had a menopause review during their visit with a HIV physician but 39% had menopausal symptoms which would have been identified if questioned.
- 23% had heard of HRT and only half of them had been given this information from a healthcare professional. Otherwise they had heard about it through word of mouth and no information had been given/sought about whether they would be eligible or it may help with their menopausal symptoms.
- 61% of the women questioned were still having regular periods, with no symptoms of menopause, but given their age, are likely to reach menopause in the near future so would be worth discussing symptoms/signs in advance and as well as information around Hormone Replacement Therapy (HRT).
- Only 1 of the symptomatic women had discussed the menopause with their GP and started HRT which they found beneficial.

Discussion

- Women with HIV are more likely to undergo premature menopause and hence it is very important to enquire about menopause at least once a year in their annual review. A comprehensive review to include their FRAX, cardiovascular risk scores, their current antiretroviral regimen, pharmacological review to identify any drug-drug interactions in women of this age group is crucial to minimise any drug related side effects.
- Information on HRT should be made readily available for these women.
- Following review of our results, we believe that women living with HIV should have access to specialist menopause care.

Conclusion

This survey has highlighted that menopausal symptoms are extremely common in women of the specified age group. Based on our survey we aim to improve 'menopausal awareness' by not only identifying the issues in our annual review but also providing information and guidance to deal with menopause.

Acknowledgement

The authors acknowledge all HIV physicians in NUH for sharing their cases to contribute to this project.

References:
 BHIVA guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2016 (2016 interim update): <http://www.bhiva.org/HIV-1-treatment-guidelines.aspx>
 FSRH HIV in the UK 2015 Report: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/602743/HIV_in_the_UK_report.pdf
 BHIVA/BASHH/FSRH guidelines for the sexual and reproductive health of people living with HIV 2017: <https://www.bhiva.org/journals/bhiva-bashh-fsrh-guidelines-for-consultation-2017.pdf>
 Menopause: Diagnosis and Management (NICE 2015)

CONTRACEPTION >40YRS

Copper coil (inserted after 40 yrs)

Remain insitu for:-

2 yrs after last LMP if under 50

1 yr after last LMP if over 50

(Extended use, regardless of 10 yr life span)

Mirena can be used as contraception until 55, if inserted at 45Yrs or over

COC – If smoking and over 35ys should have stopped COC

Ethinylestradiol <30 ug first line COC when >40yrs (lower VTE risk)

Can be used as pseudo HRT until 50

CONTRACEPTION >50YRS

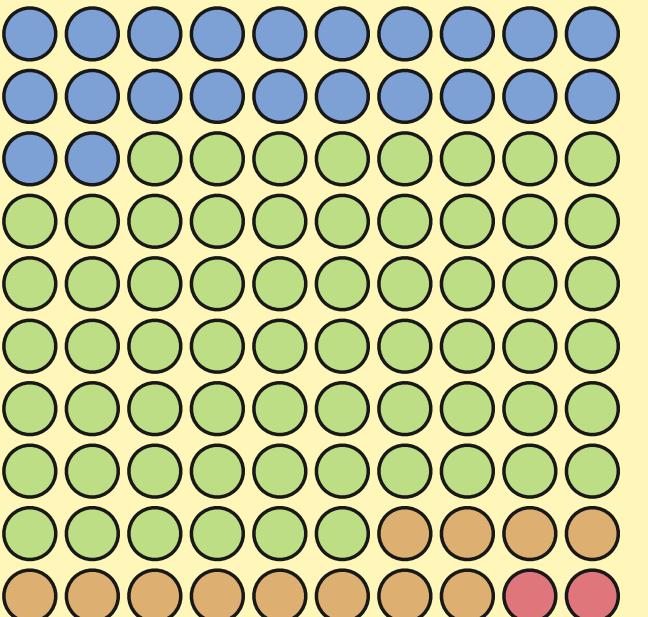
DMPA - Counsel the over 50's on alternative options

COC - Stop, use alternative

Generally women can stop contraception after 55 yrs

CYTOTOLOGY

Cytology

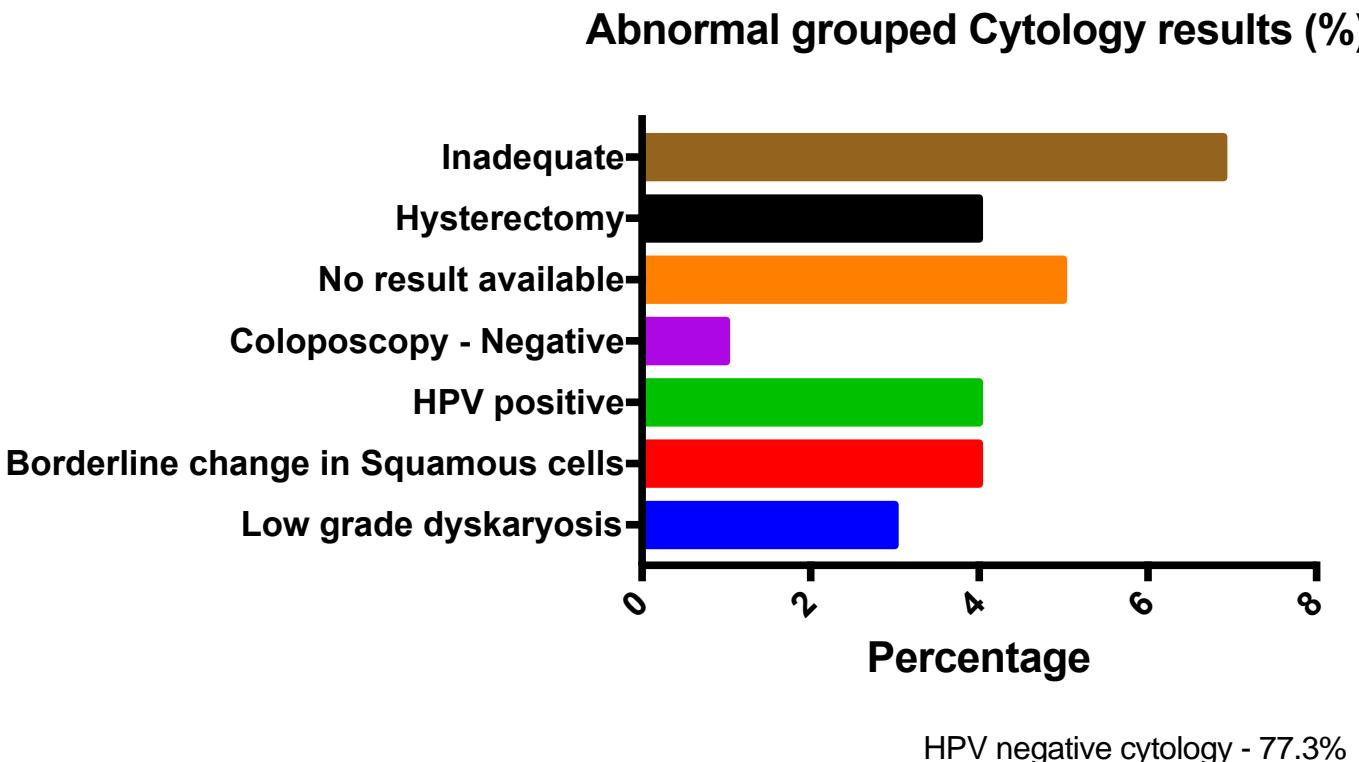


- Not up-to-date (11)
- Uptodate (32)
- Not appropriate (inc declined) (6)
- Not documented (1)

Audit Review: Adherence to the National Recommendation of annual cervical screening for women living with HIV, 2015–2018 at Queen Elizabeth Hospital Birmingham

Background			
As women living with HIV (WLHIV) are experiencing longer life expectancy due to increased availability of combined antiretroviral therapy (cART), many remain at high risk of infection with human papillomavirus (HPV), acquiring genital warts, and progressing to cervical and other genital cancers (1). This is the same in both the African sub-continent and in Europe.			
Study aim			Results
To investigate the rates of annual cervical screening tests of WLHIV (diagnosed with HIV pre 2015) attending the centre at Queen Elizabeth Hospital Birmingham (QEHB).			A total of 452 women were identified, with a median age of 44 (IQR: 38–50) years, and 77.2% being of African ethnicity.
Table 1 – Patient Demographics		Table 3 – Results of Screening	
Year	Number of Women Screened	Recommendation Further Test at Interval Less than Routine	Recommended Referral to Cytoscopy
2015	171	32 (18.7%)	20 (11.7%)
2016	193	33 (17.3%)	16 (8.3%)
2017	149	47 (25.4%)	10 (5.4%)
2018	144	28 (18.1%)	14 (9.7%)
Total	693	138 (19.9%)	60 (8.7%)
Discussion			
Significant numbers of WLHIV (20%) in our centre have not had a cervical screen during a four year interval.			
Only a small number of WLHIV (5%) underwent an annual screen as per the national UK guidelines.			
A significant proportion of screened women (8.7%) required further investigation by colposcopy.			
Our audit suggests that the recall process for cervical screening may require a significant improvement for all women (irrespective of their HIV status) in our city.			
Following this audit we introduced a new reminder process for the GPs whereby a generic letter is re-issued to GPs to those women who have not had their annual cervical screen.			
We will audit the results of this initiative in the near future.			
References			
1. Kelly H, Faust H, Chikandwa A, Ngou J. Human papillomavirus Serology Among Women Living with HIV: Type-Specific seroprevalence, seroconversion, and risk of Cervical Reinfection: JID 2018;218(15 September):			
2. Camero C, Cascella F, Caramorosa P, Lepera A, Bettocchi S, Vlimercati A. Colposcopy abnormalities in HIV infected and uninfected pregnant women: prevalence, persistence and progression. Journal of Obstetrics and Gynaecology. 38(4): 526-531. DOI:10.1080/0143615.2017.1373082			
3. University Hospitals Birmingham NHS Foundation Trust. Building healthier lives. NHS. Available from: www.uhb.nhs.uk			

CYTOLGY RESULTS



BSCCP – 5% of patients will have an abnormal cytology result
 CRI data – 11% of patients had clinically abnormal

Is it time to review the recommended intervals of cervical cytology in women living with HIV (WLHIV)?

M Itty Samuel ¹, Kate Flanagan ¹, Lisa Hamzah ¹, Alejandra Castanon ², Verity Sullivan ¹, Chris Taylor ¹
¹Department of Sexual Health & HIV, Kings College Hospital NHS Foundation Trust
²King's College London | Faculty of Life Sciences & Medicine, Guys Hospital, London SE1 9RT

Background

Rates of cervical intraepithelial neoplasia (CIN) and invasive cervical cancer are higher in women living with HIV (WLHIV) compared to the non-HIV population and are associated with severity of immunosuppression. Effective antiretroviral therapy (ART) reduces the risk of abnormal cytology. The NHS Cervical Screening Programme (NHSCSP) guidelines recommend yearly cervical cytology tests for all WLHIV between the ages of 25-65 years. However, the Centre for Disease Control and Prevention (CDC) recommend that after 3 consecutive normal annual cytology results or where one cytology result is normal and subsequent high-risk human papilloma virus (hrHPV) testing is negative, the screening interval may be extended to three-yearly.

Aim

To determine the need for annual cervical screening in WLHIV.

Methods

A retrospective case note review of all HIV-positive women attending the nurse-led cervical cytology clinic of our HIV outpatient department between 01/01/14 and 31/12/18 was undertaken (48 months). Data of cytology results also collected prior to these results were analysed using SPSS.

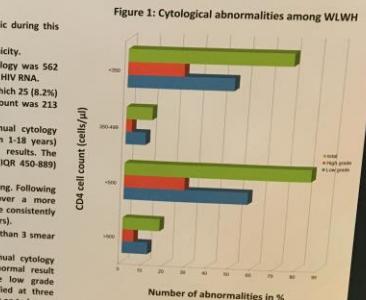
Results

- 305 women attended the cervical cytology clinic during this period (mean age 44.4 years (SD 9.34)).
- 91% identified as black African or Caribbean ethnicity.
- Median CD4 count at the time of cervical cytology was 562 (IQR 318-775) cells/ μ l. 78% had an undetectable HIV RNA.
- 78 (25.4%) had an abnormal cytology result of which 25 (8.2%) were high grade cytology with a median CD4 count was 213 (IQR 139-380) cells/ μ l.
- 143 (47%) had three normal consecutive annual cytology results and during follow up (ranging 1-18 years) went on to have consistently normal cytology results. The median CD4 count of these women was 679 (IQR 450-889) cells/ μ l.
- 95 women did not attend every year for screening. Following three consecutive 'normal' cytology results over a more extended time period they also went on to have consistently normal cytology results during follow up (1-7 years).
- The remaining 25 had normal cytology but less than 3 smear results.
- 10 women had three normal consecutive annual cytology results and subsequently developed an abnormal result during 1-8 years of follow up. These women had three yearly intervals which would have been identified at three yearly interval screening. 7 of these women went on to have a normal cytology results following this low grade abnormality.
- Cytological abnormalities were significantly higher in the women with CD4 count <500 ($P=0.001$).
- 31 women had previous treatment for CIN and went on to have consistently yearly normal cytology results during follow up.
- 23 women who had normal smear following an abnormal smear and persisted normal during follow up (1-9 years).

Conclusion

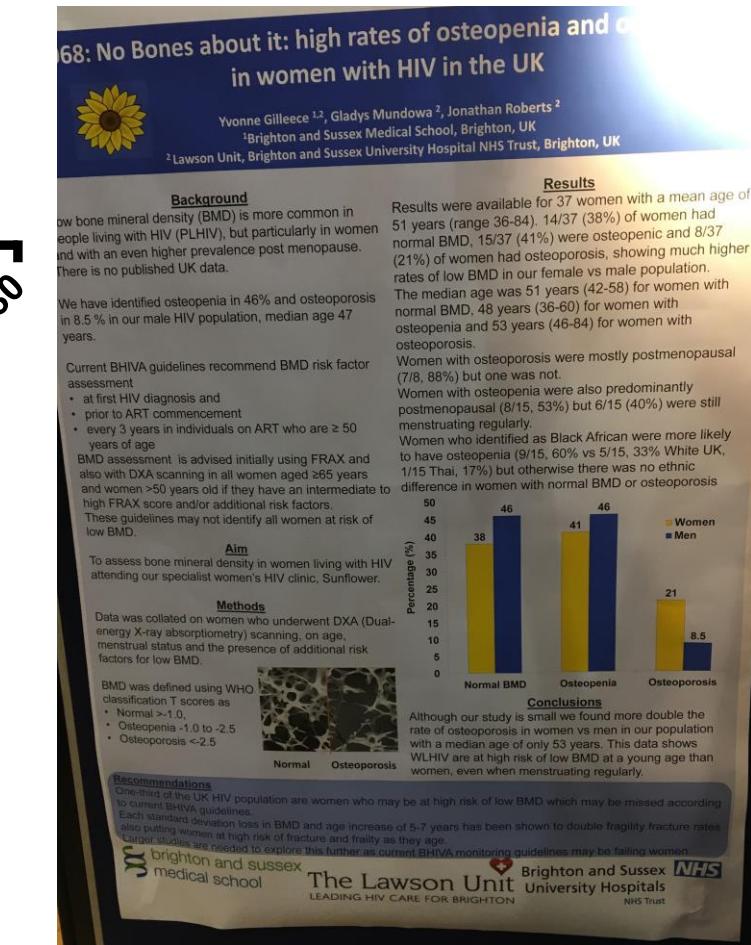
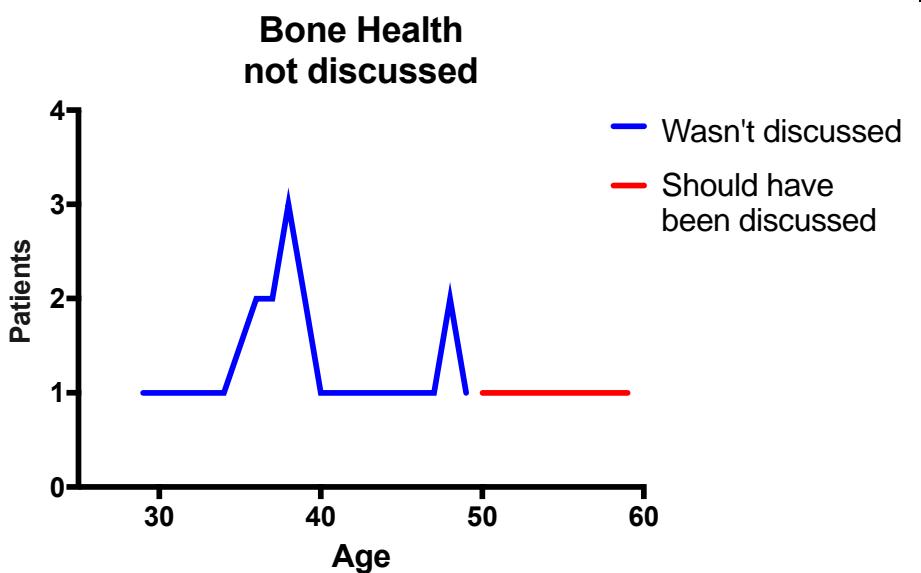
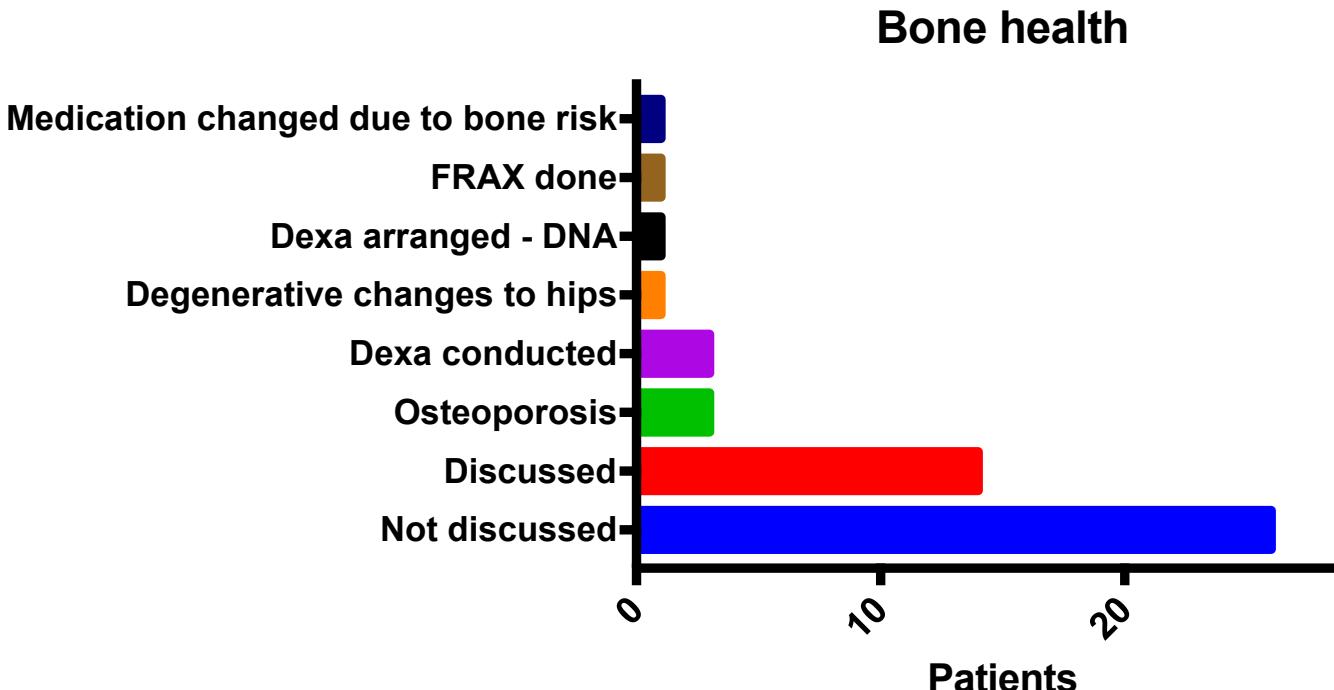
In our cohort, low grade (17.2%) and high grade (8.2%) cervical cytological abnormalities were found at a higher prevalence than in the general population (5% and 1.3% respectively). Results from this small retrospective cohort suggest that for women with an undetectable viral load and preserved CD4 count with three normal consecutive annual cytology results, longer intervals between cervical cytology tests may be appropriate. This would be cost saving for the department and reduce the number of outpatient appointments undertaken by WLHIV. Further research is required, specifically to assess the significance of other risk factors for cervical abnormalities (e.g. smoking, hrHPV results) in this group.

Abbreviations: CD4 = small numbers of patients; lacking data on other risk factors for cervical abnormalities such as hrHPV data and smoking.



KING'S HEALTH PARTNERS
Improving Lives. Improving Care. Improving Lives.

BONE HEALTH



SUMMARY

6 month reviews



Smoking discussed



CVR



Alcohol intake lower than Cardiff average



Depression higher than average



ARVs – Backbones



STRS



Third agent



Contraception



Menopause

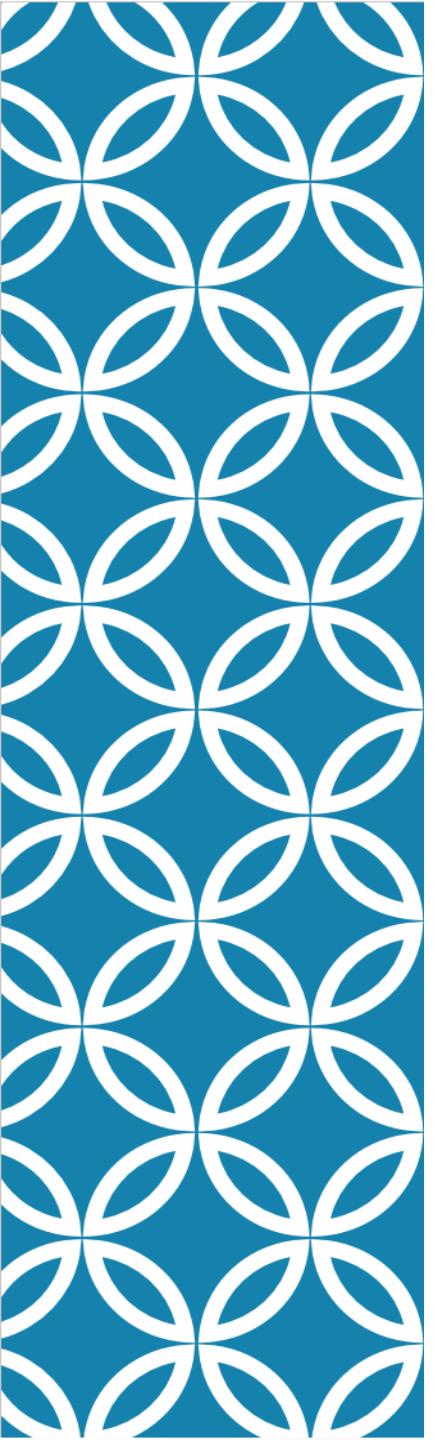


Bone



Cytology





CONCLUSIONS

The service is meeting five of eight recommended screening criteria

Service needs to plan how can new HIV Nurse Practitioners help to meet the needs of female patients?

Need to consider if historic PI patients can come off their PI

How can we help more with depression?

- Third sector involvement?

Do we need separate female clinics?

CHIVA involvement for families

Are HIV clinics still the best place for females?

QUESTIONS



THANKS TO:-

