nhivna
NATIONAL HIV NURSES ASSOCIATION
support | research | education

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

27–28 June 2019 · Manchester Conference Centre

WHO RUNS THIS MOTHER F*** WORLD

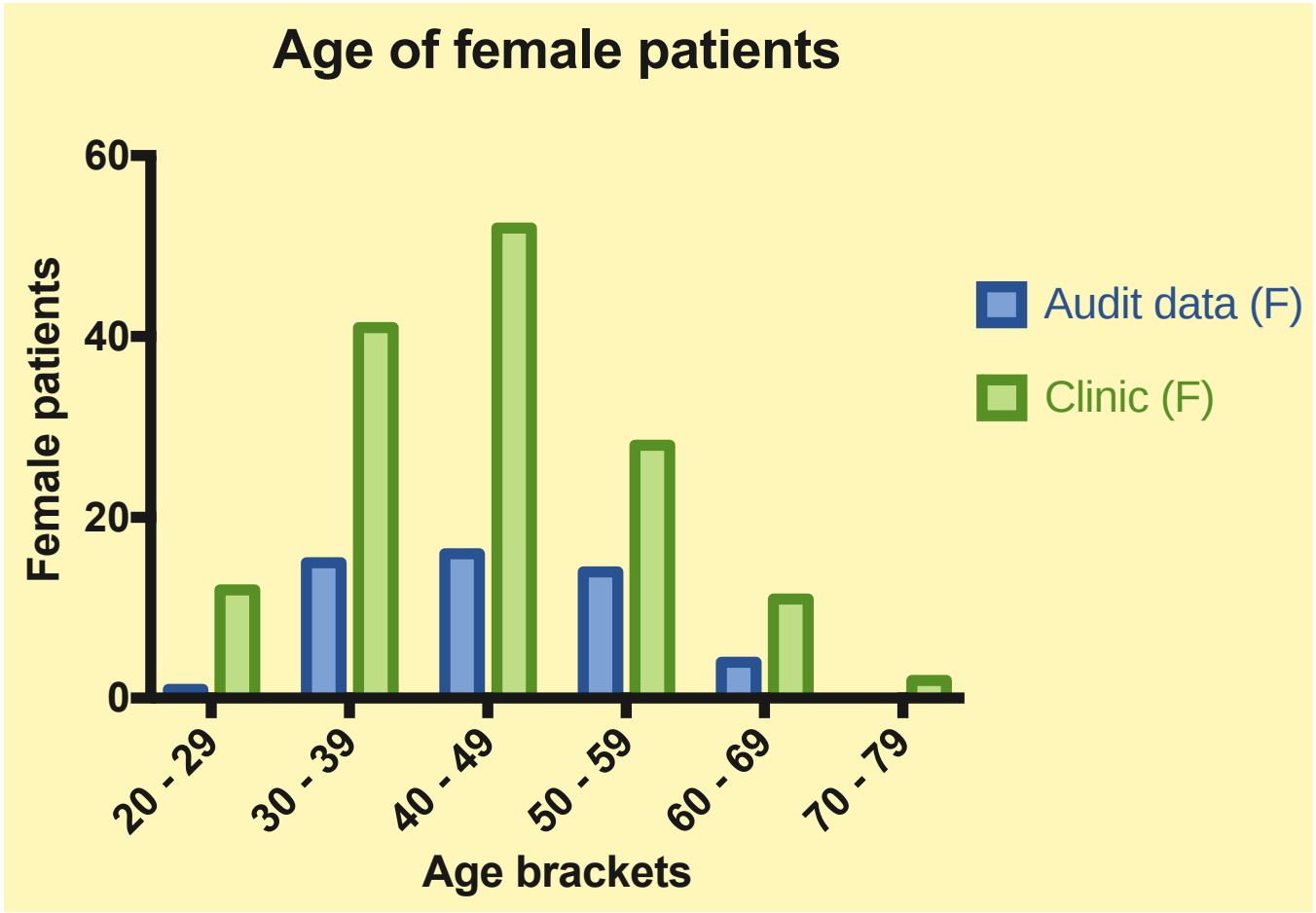
Stewart Attridge
HIV ANP
Cardiff Royal Infirmary
Cardiff & Vale UHB

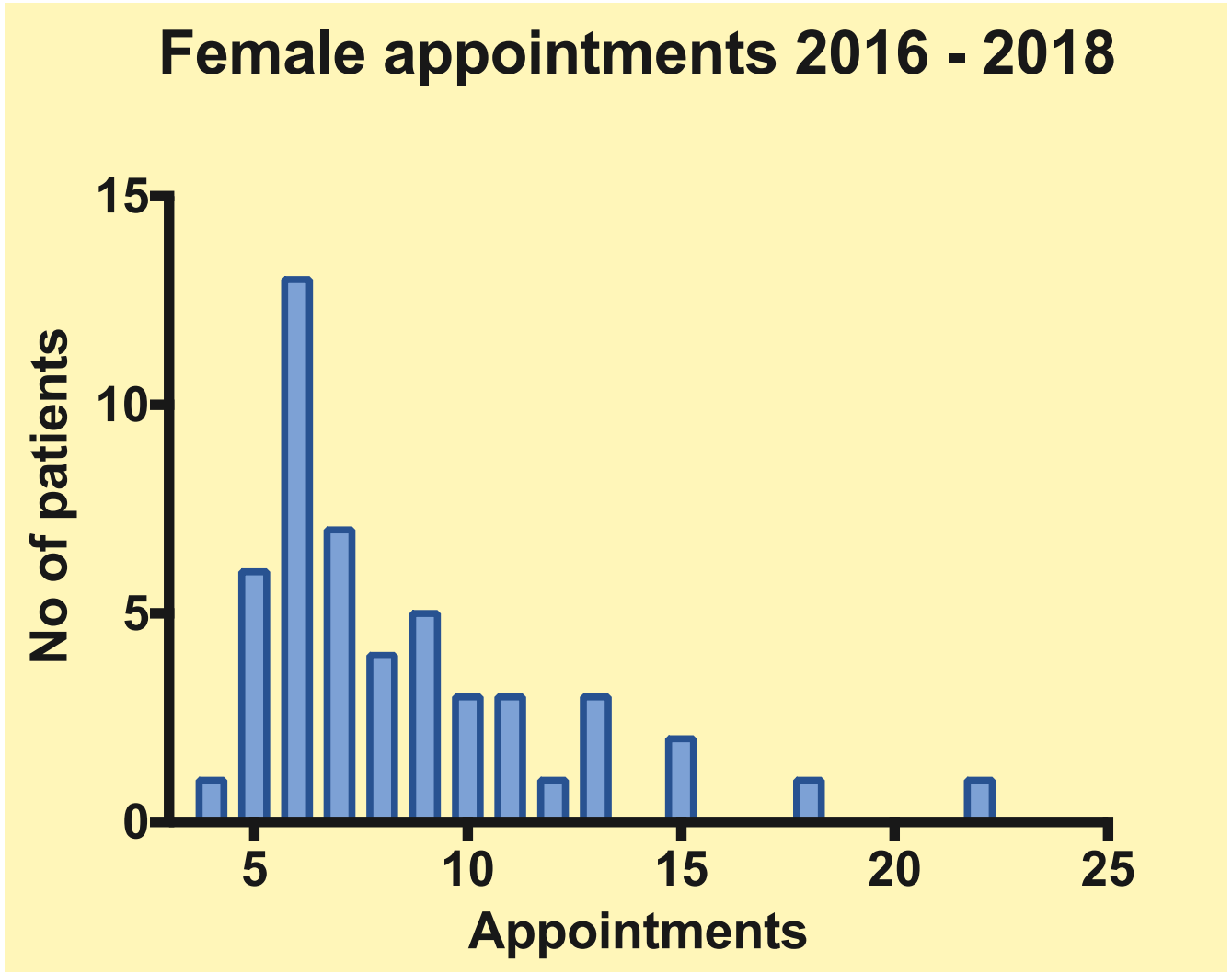
CONTENTS

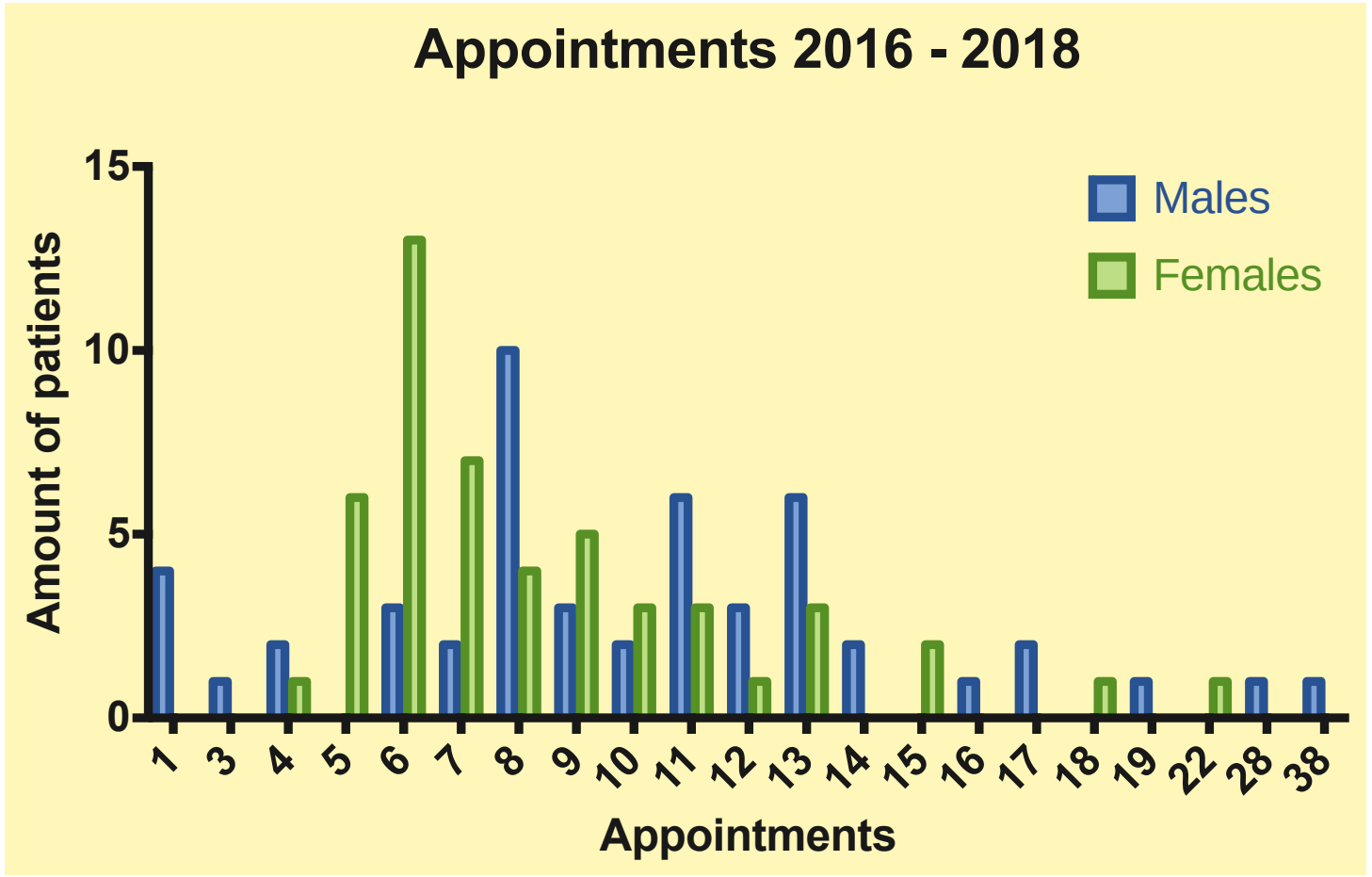
- ♀ CRI cohort
- ♀ Female appointments
- ♀ Lifestyle factors
- ♀ PMH
- ♀ ARVs & Switches
- ♀ Contraception
- ♀ Menopause
- ♀ Cytology

Review of Clinical notes
2016 - 2018

AUDIT DATA


Age of female patients
Female patients
60
40
20
0
20 - 29
30 - 39
40 - 49
50 - 59
60 - 69
70 - 79
Age brackets
Audit data (F)
Clinic (F)


Female appointments 2016 - 2018
No of patients
15
10
5
0
5
10
15
20
25
Appointments



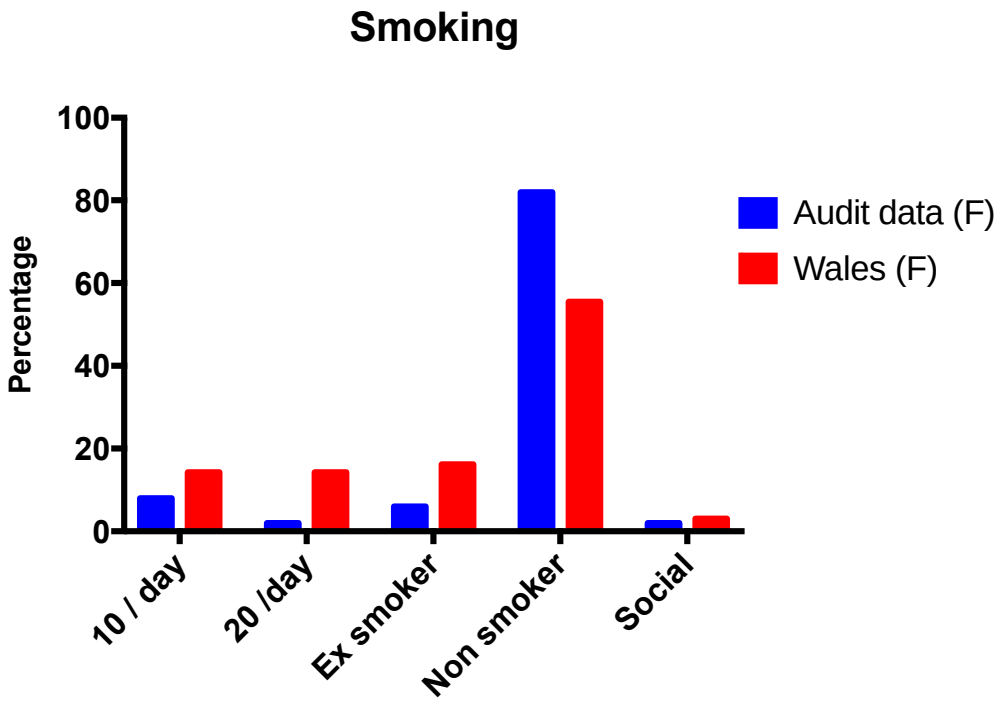
Appointments	Males	M(%)	Females	F (%)
1 to 6	10	**20**	20	**40**
7 to 10	17	**34**	19	**38**
11 to 16	18	**36**	9	**18**
17 to 38	5	**10**	2	**4**

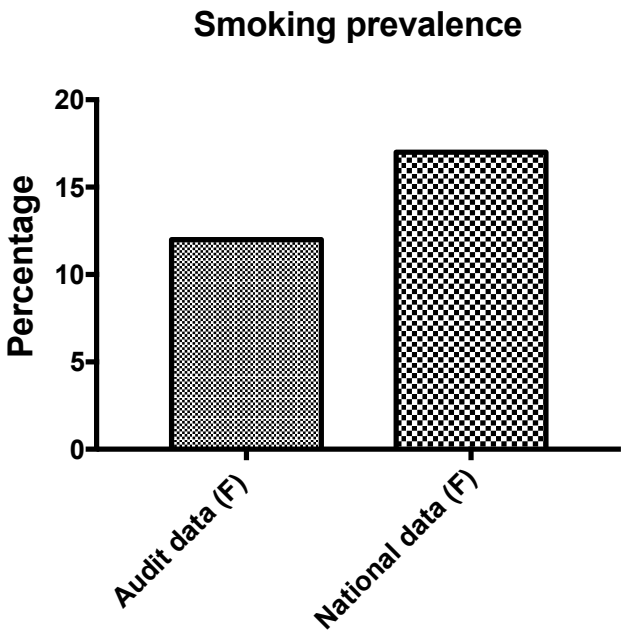
SMOKING

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%).

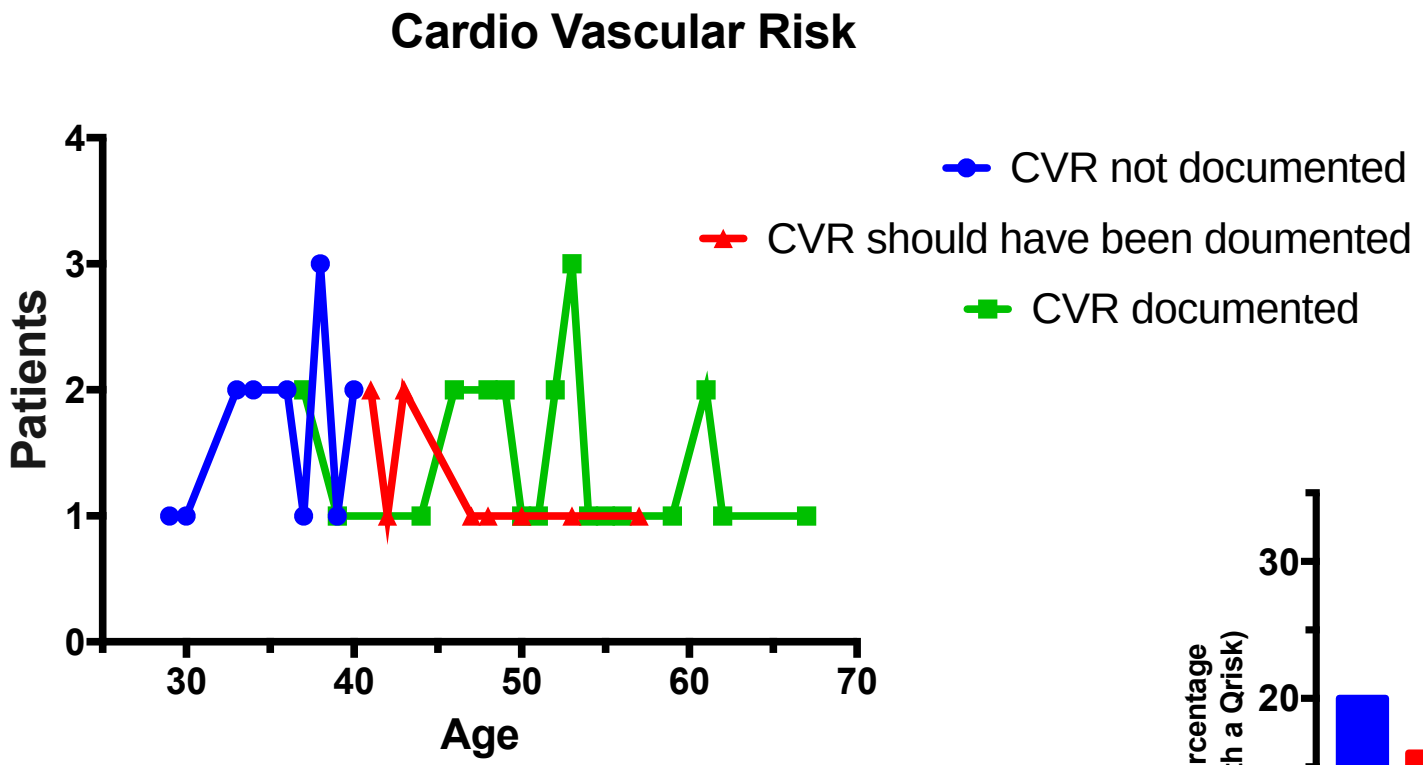
BHIVA Standards of Care 2018





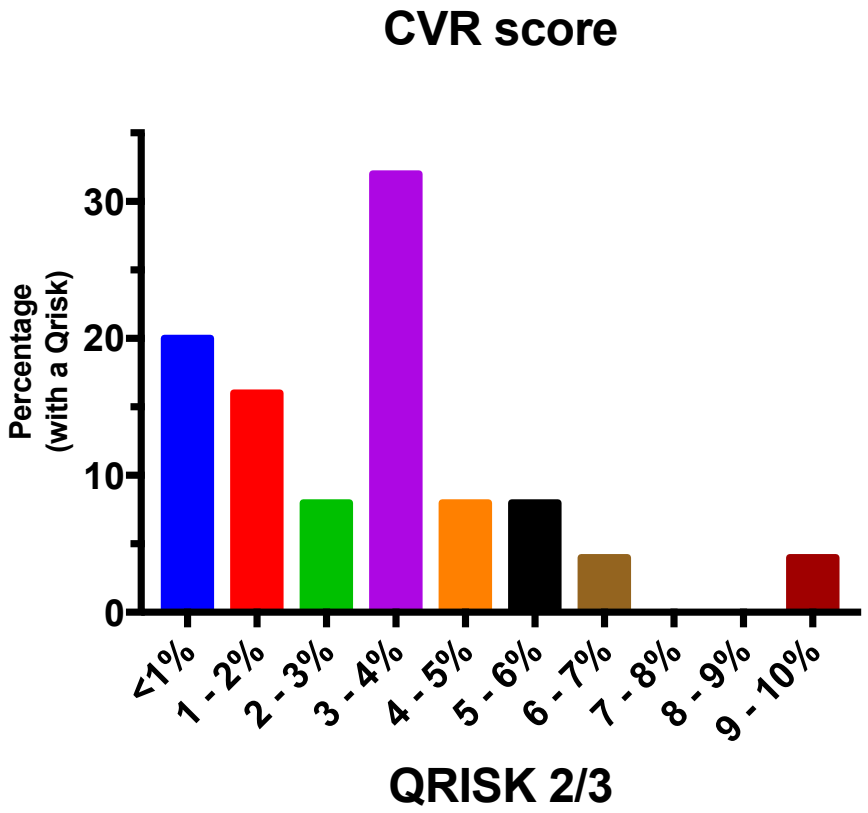
CARDIO VASCULAR DISEASE

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

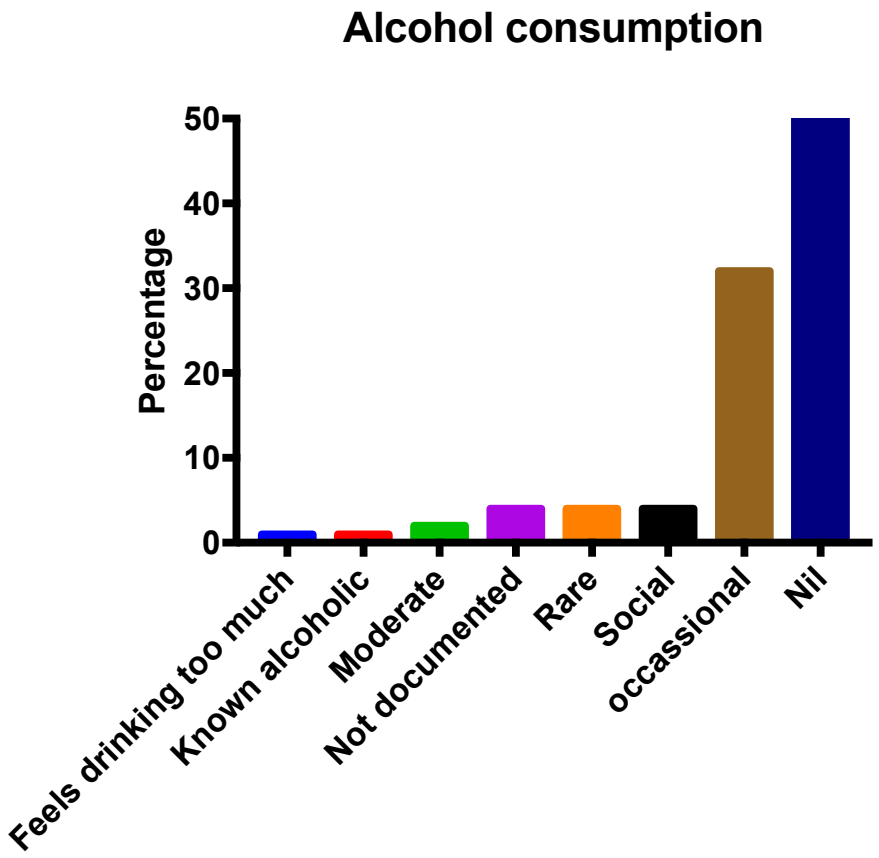


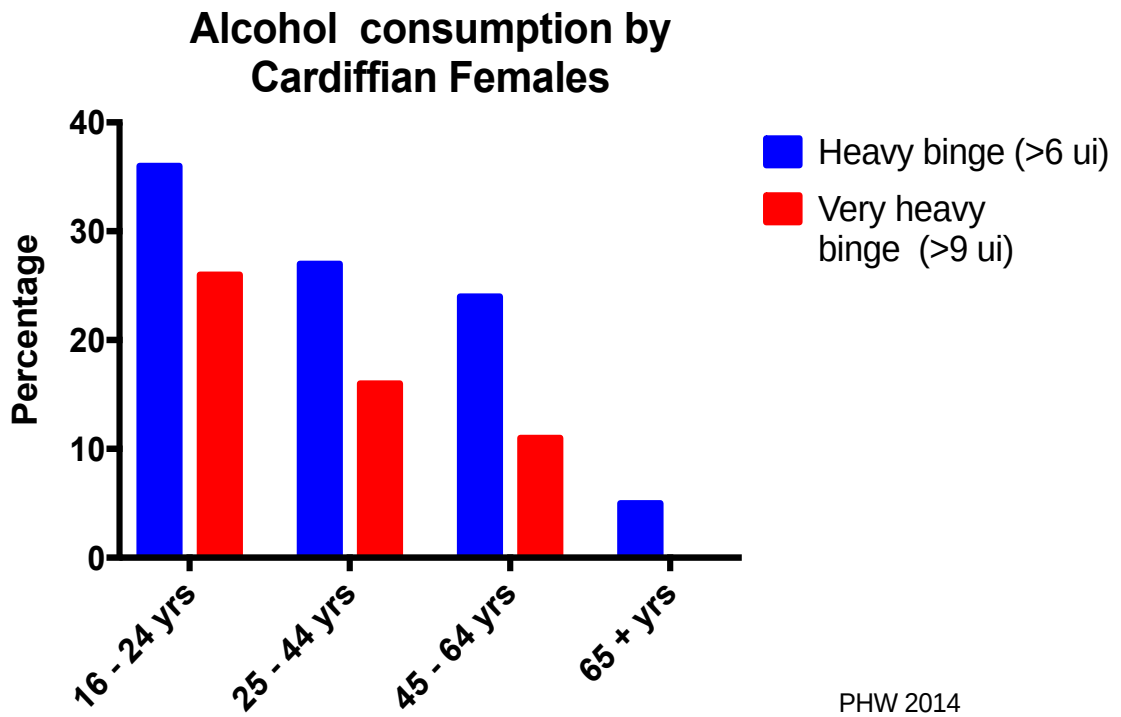
CVR not documented in 50% of patients

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



SUBSTANCE MISUSE

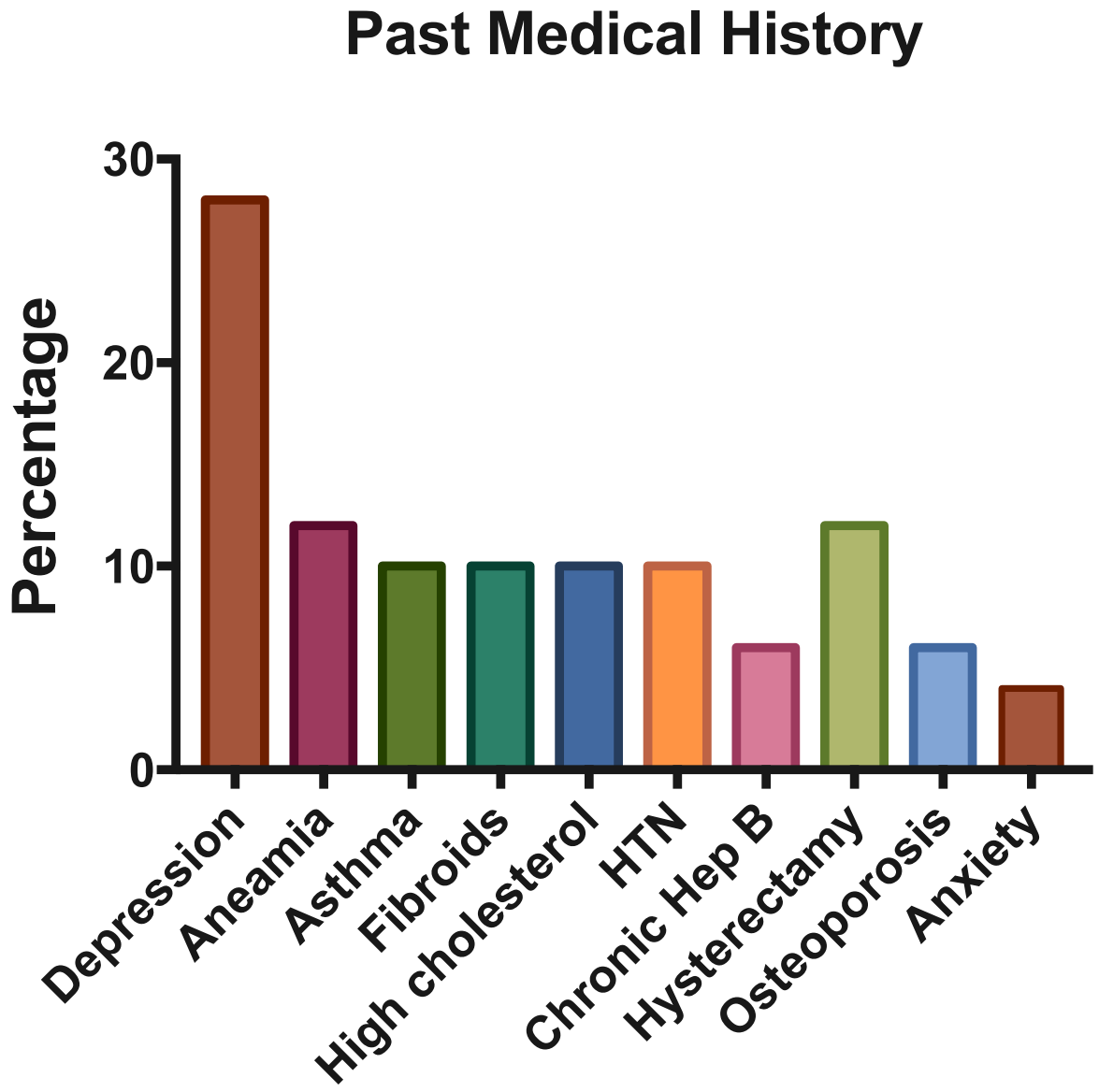


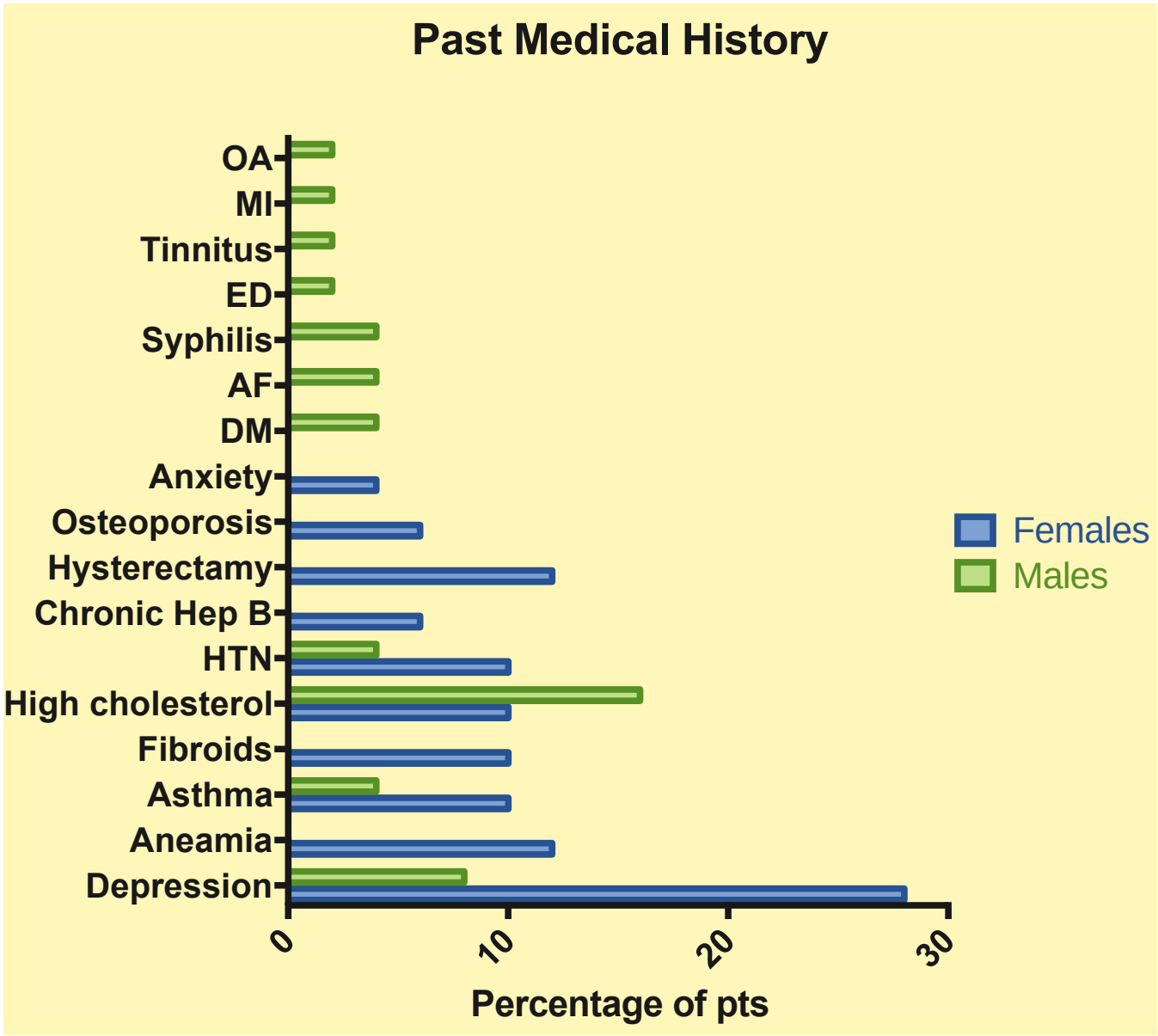


PHW 2014

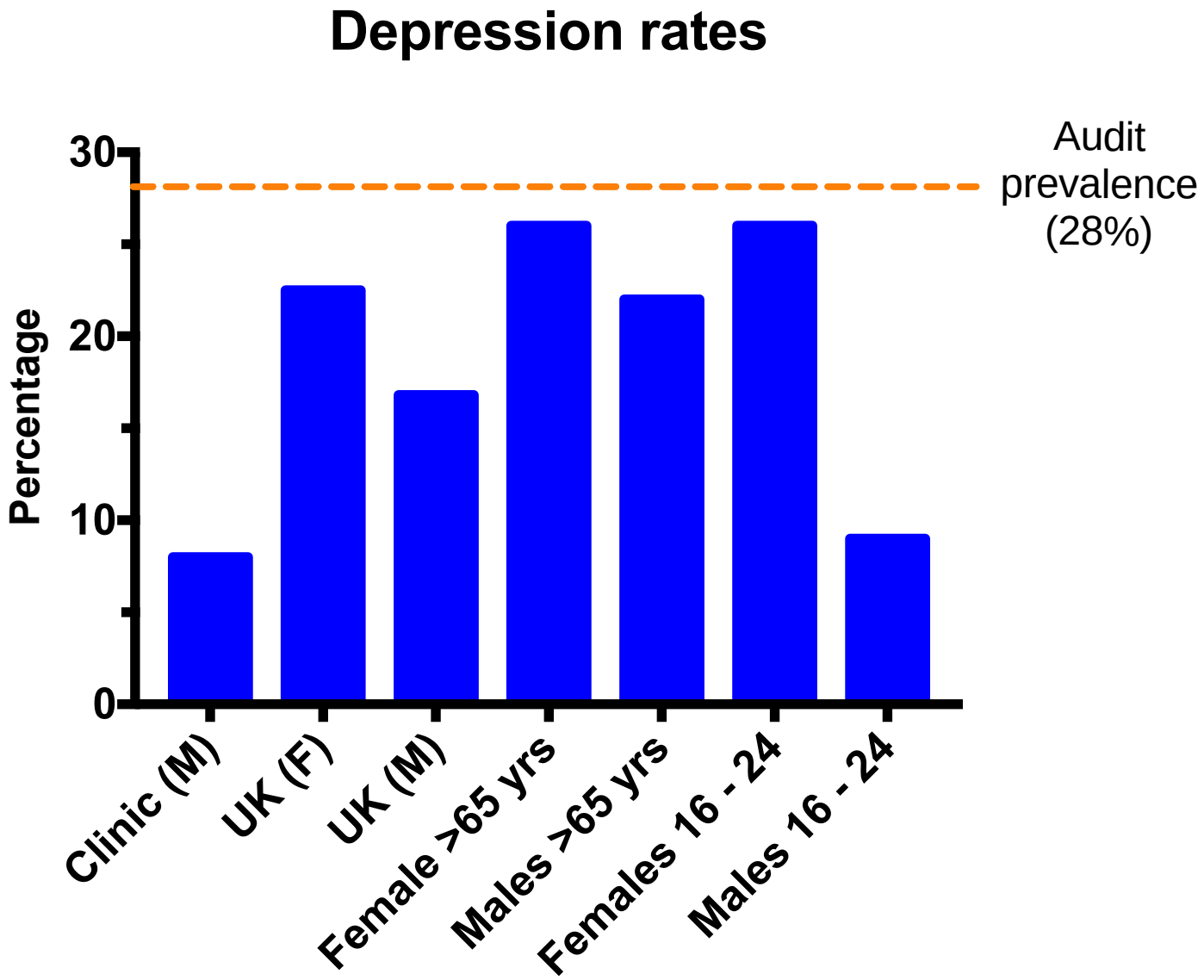
Recreational drugs	No of patients
Nil	1
Smokes crack	1
Not documented	2
Nil	46
Grand Total	50

PAST MEDICAL HISTORY



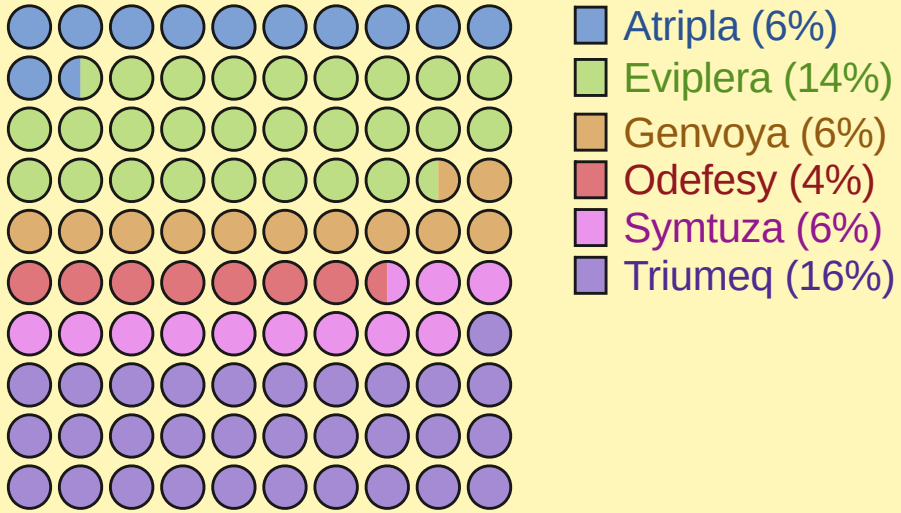

Past Medical History
OA
MI
Tinnitus
ED
Syphilis
AF
DM
Anxiety
Osteoporosis
Hysterectamy
Chronic Hep B
HTN
High cholesterol
Fibroids
Asthma
Aneamia
Depression
0
10
20
30
Percentage of pts
Females
Males

DEPRESSION

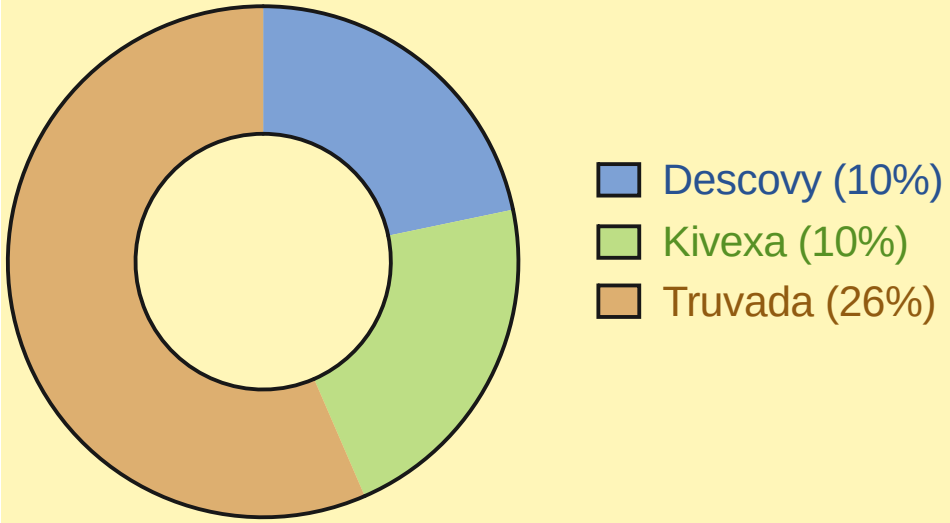

Depression rates
Percentage
30
20
10
0
Audit prevalence (28%)
Clinic (M)
UK (F)
UK (M)
Female >65 yrs
Males >65 yrs
Females 16 - 24
Males 16 - 24

ARVS

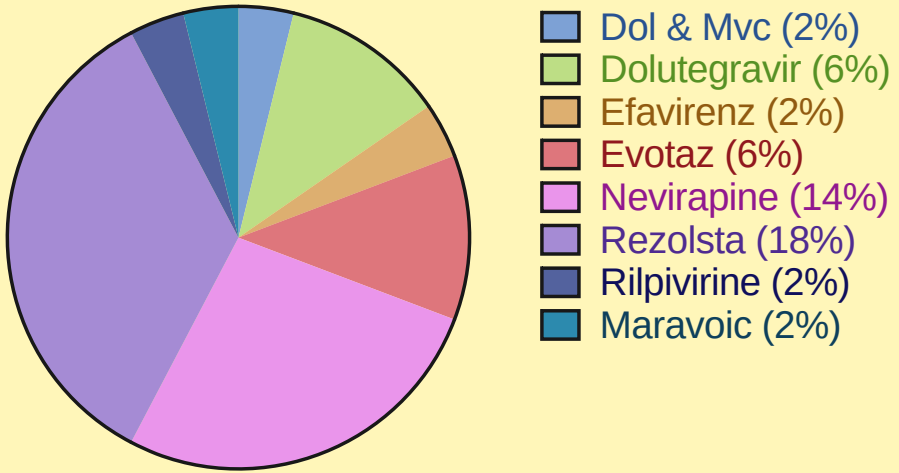
ARVs - Single Tablet Regimes



ARVs - NRTIs

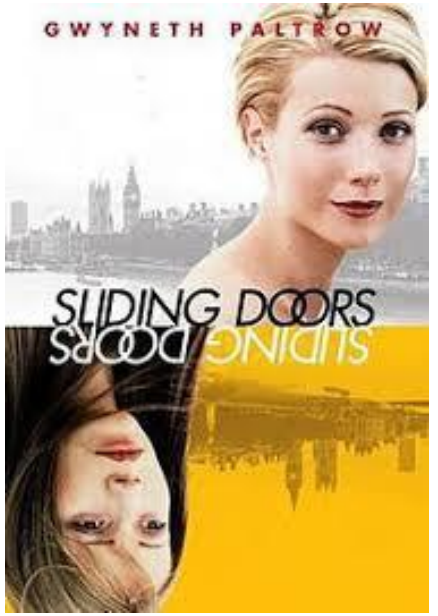


NNRTIs / PIs / Integrase

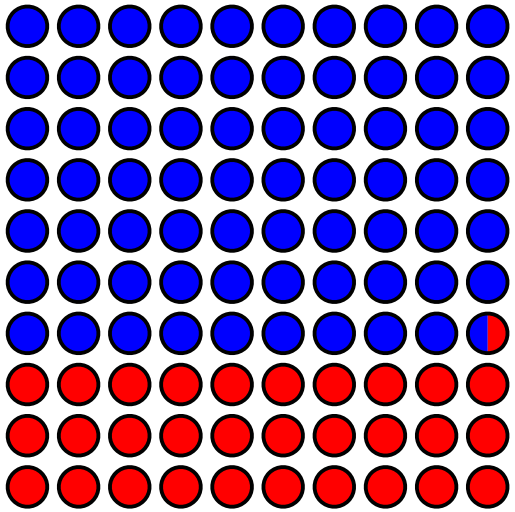


SWITCHES

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



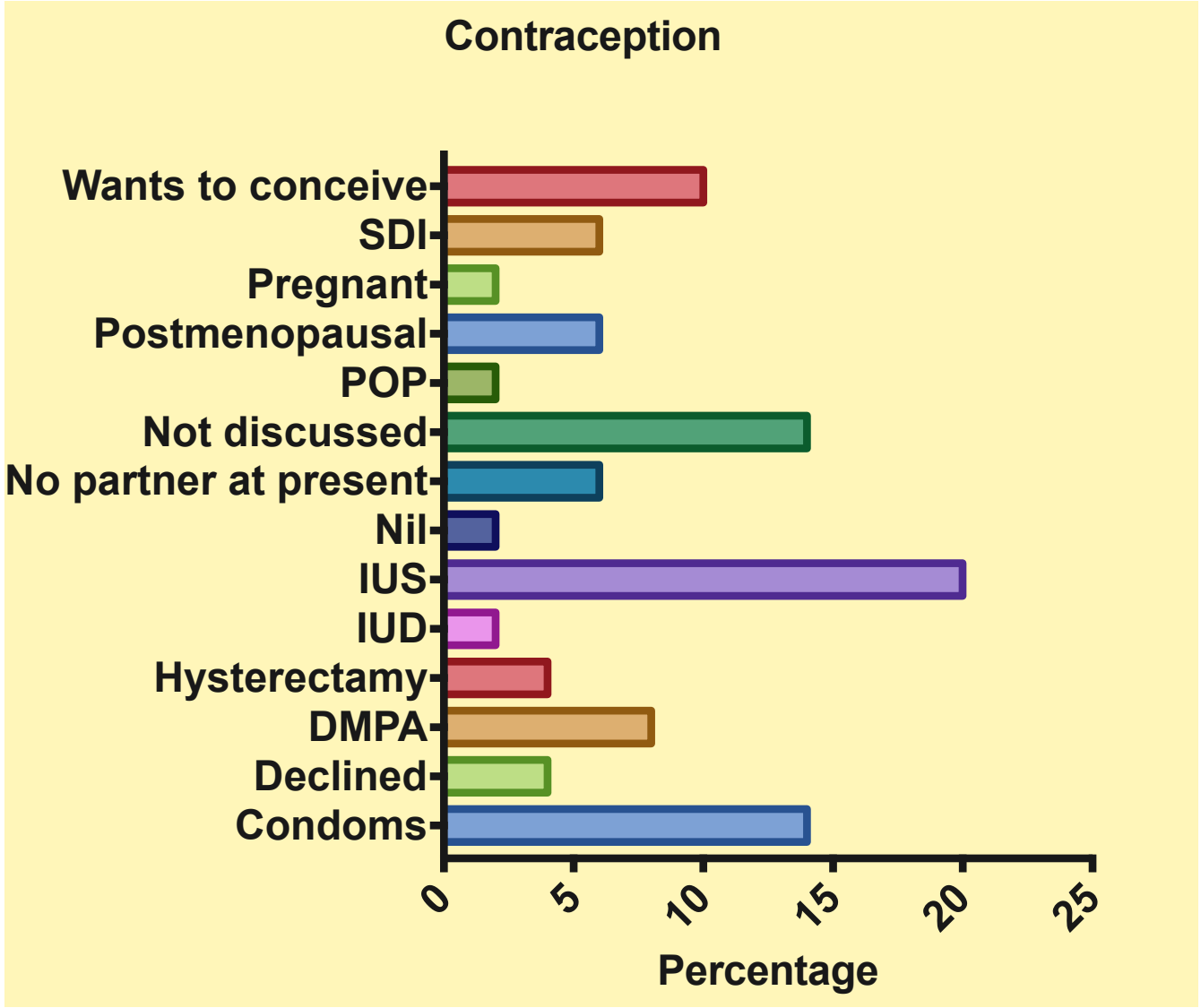
Number of switches



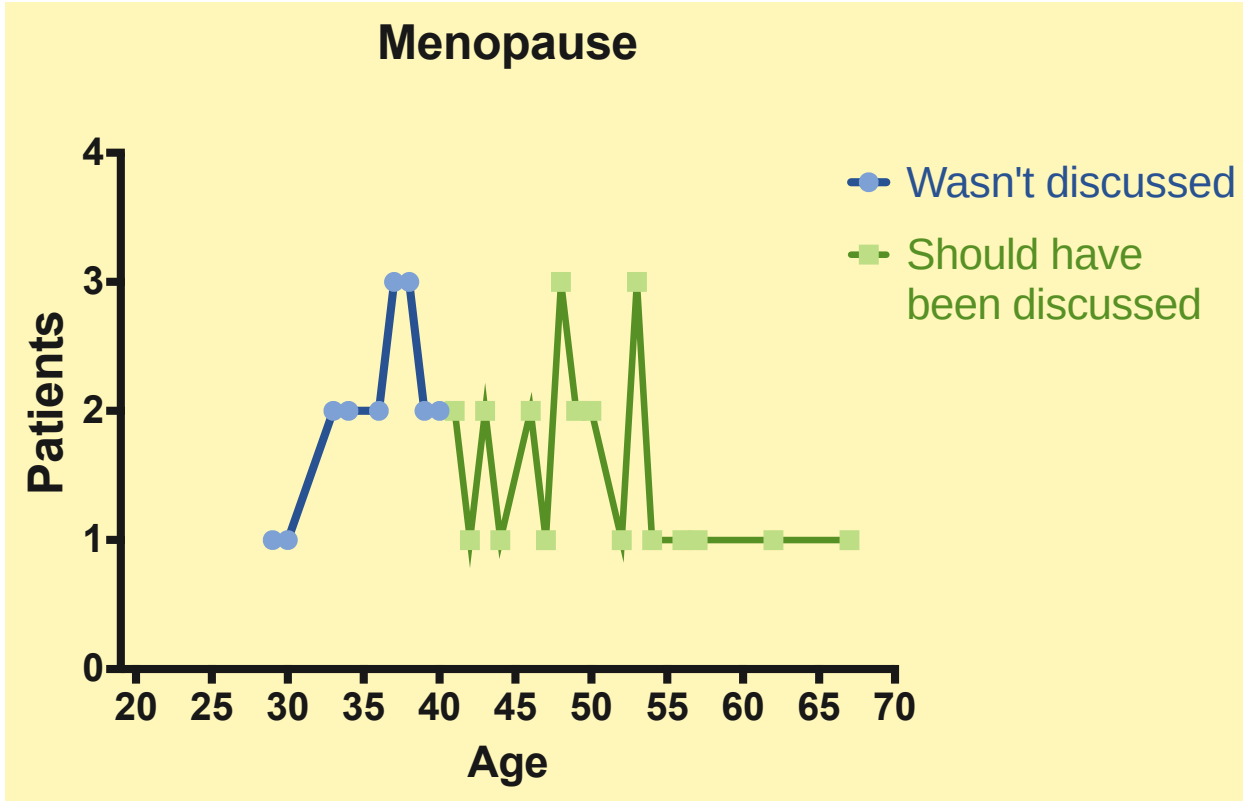
1 Switch (N=23)
2 Switches (N=10)

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



Vasomotor
- Hot flushes, sweats

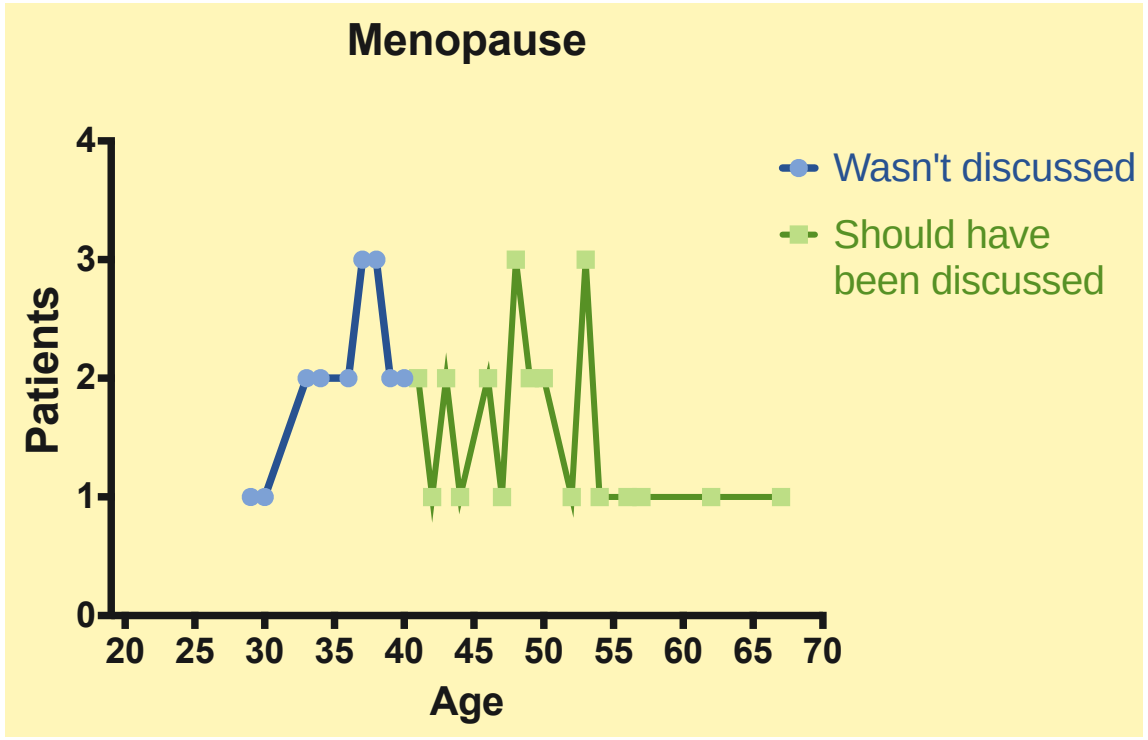
Musculoskeletal
- Joint & muscular pain

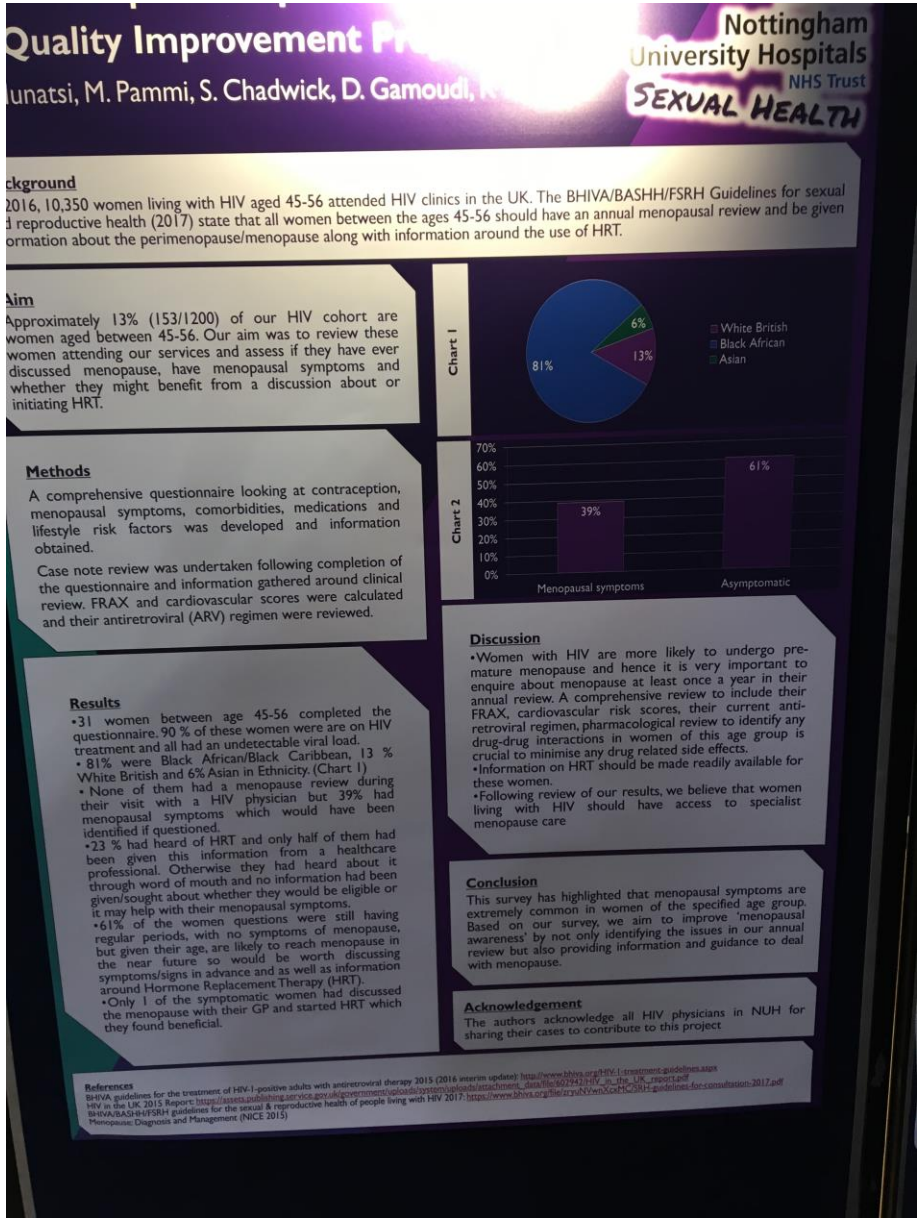
Mood
- Depression
- Low libido

Urogenital
- Vaginal dryness

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)


Menopause
Patients
Age
0
1
2
3
4
20
25
30
35
40
45
50
55
60
65
70
Wasn't discussed
Should have been discussed


Quality Improvement
Nottingham University Hospitals NHS Trust
SEXUAL HEALTH
Background
Aim
Methods
Results
Discussion
Conclusion
Acknowledgement
References
Chart 1
Chart 2
White British
Black African
Asian
81%
13%
6%
Menopausal symptoms
Asymptomatic
39%
61%

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

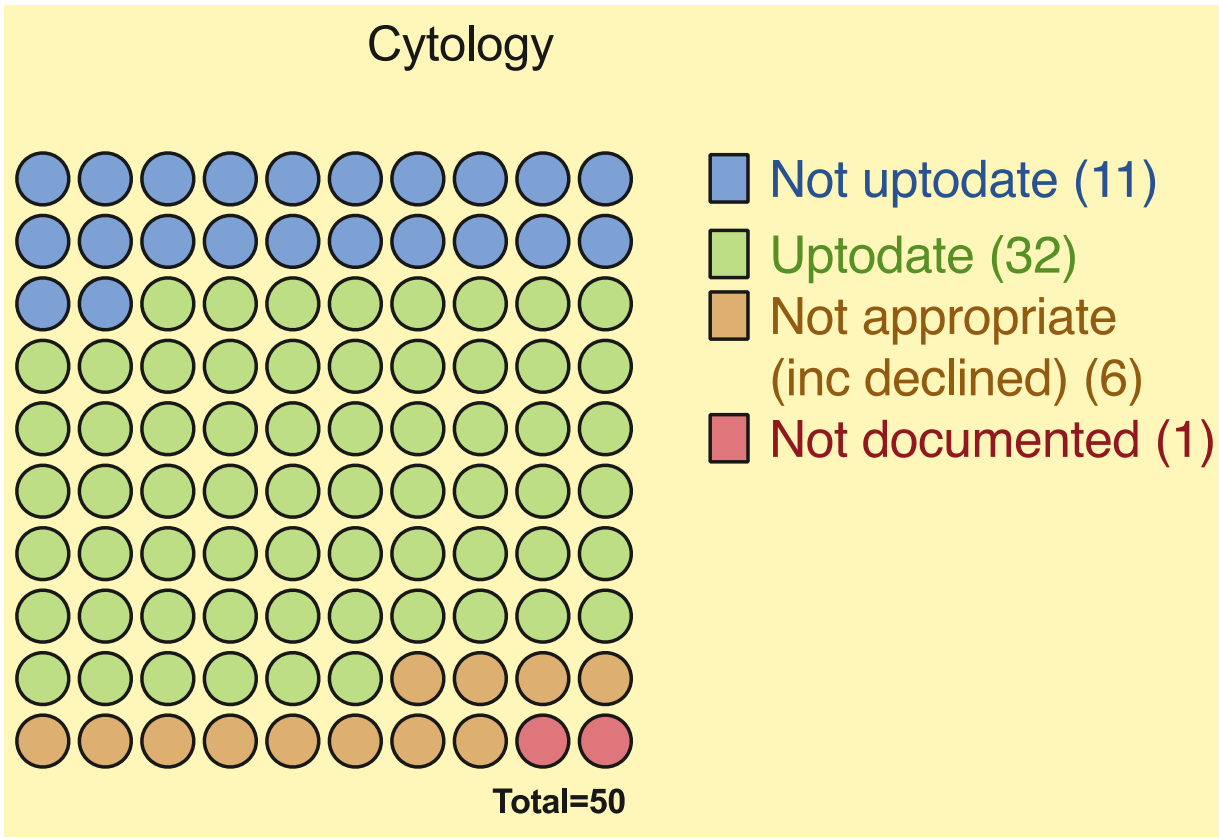
COC – If smoking and over 35ys should have stopped COC
Ethinylestradiol <30 ug first line COC when >40yrs (lower VTE risk)
Can be used as pseudo HRT until 50

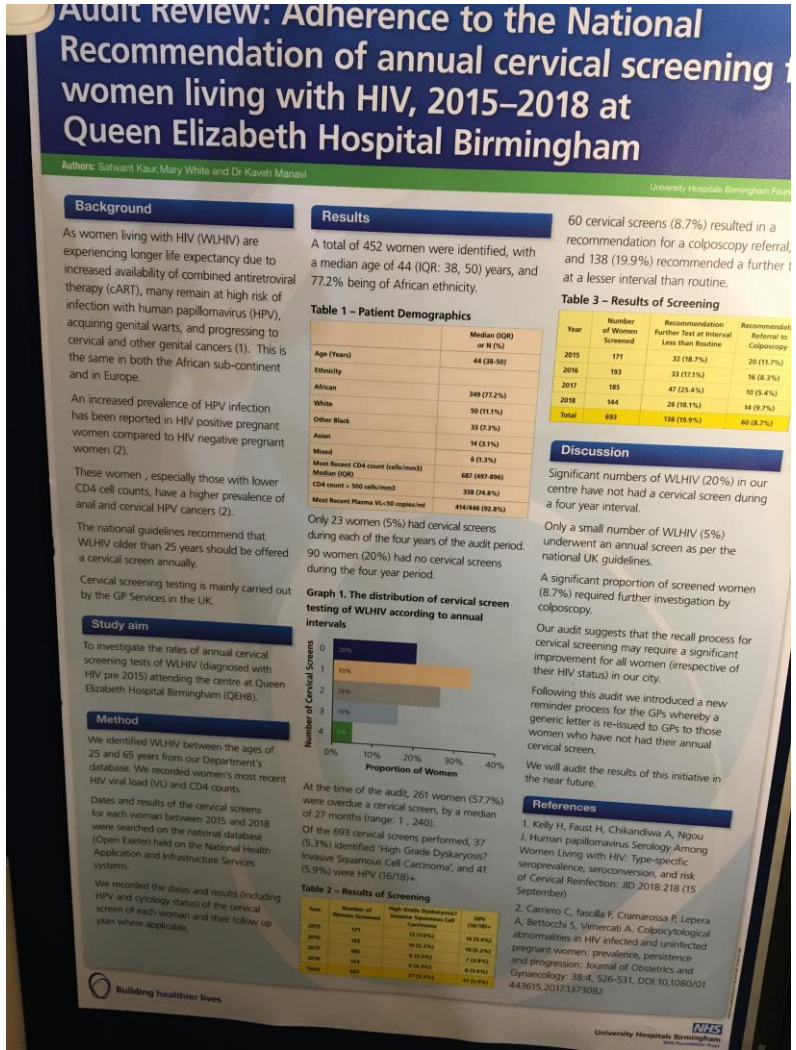
CONTRACEPTION >50YRS

DMPA - Counsel the over 50's on alternative options
COC - Stop, use alternative

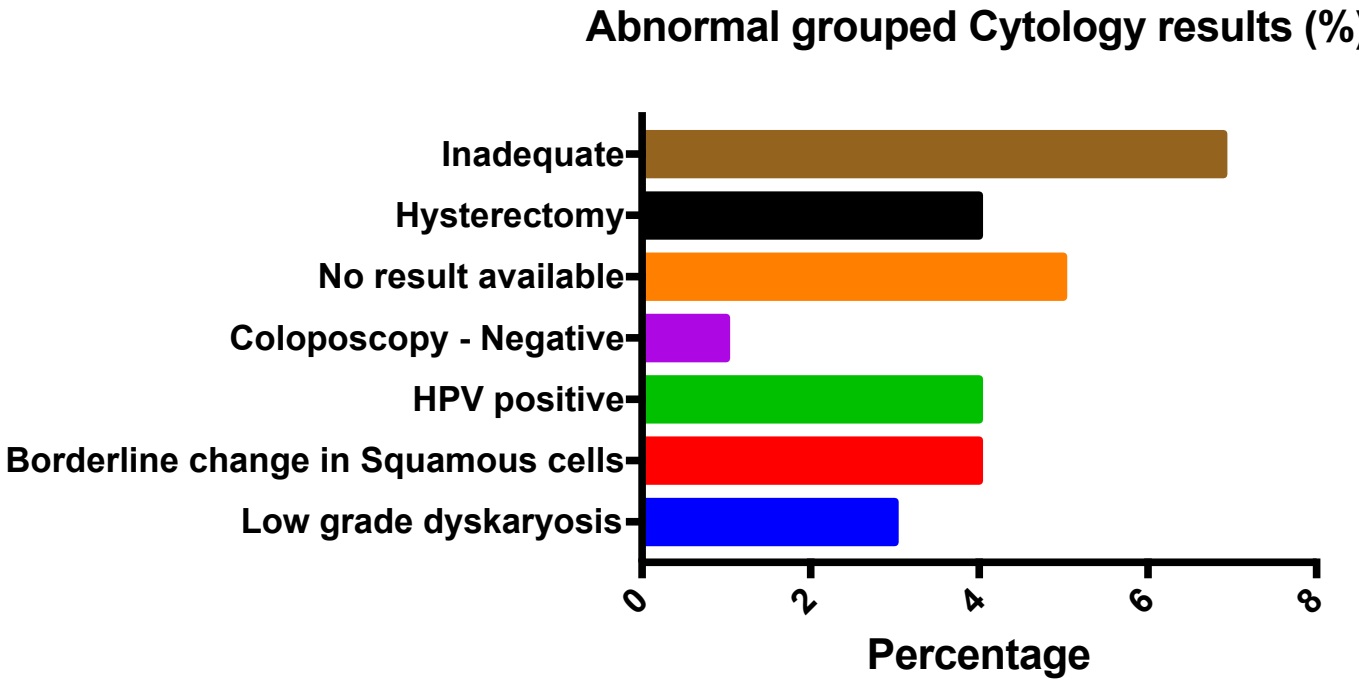
Generally women can stop contraception after 55 yrs

CYTOLOGY

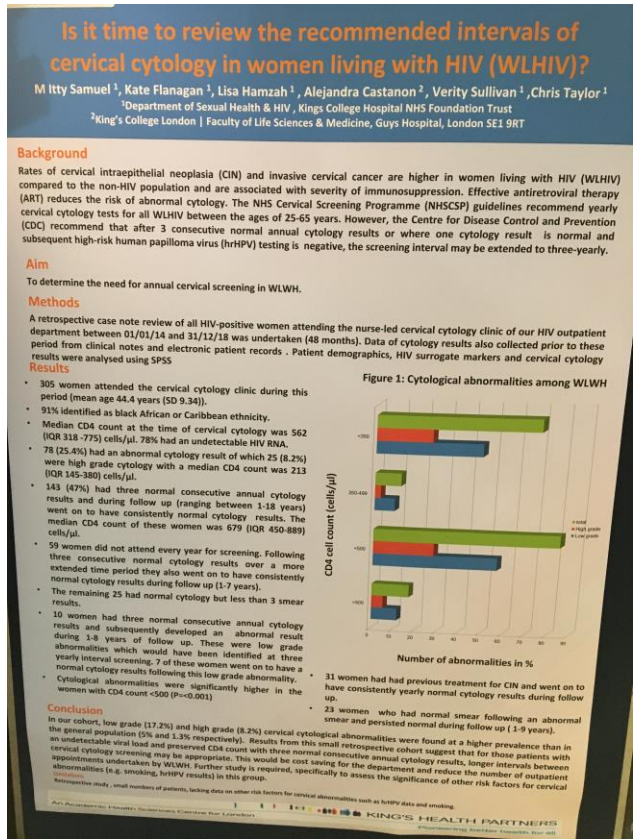

Cytology
Not uptodate (11)
Uptodate (32)
Not appropriate (inc declined) (6)
Not documented (1)
Total=50


Audit Review: Adherence to the National Recommendation of annual cervical screening
women living with HIV, 2015–2018 at
Queen Elizabeth Hospital Birmingham
Authors: Satwant Kaur, Mary White and Dr Kaveh Manavi
Background
Results
Discussion
References

CYTOLOGY RESULTS



HPV negative cytology - 77.3%


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]

[1]Department of Sexual Health & HIV, Kings College Hospital NHS Foundation Trust

[2]King'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 WLWH.

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 period from clinical notes and electronic patient records . Patient demographics, HIV surrogate markers and cervical cytology 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/µl. 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 145-380) cells/µl.
- 143 (47%) had three normal consecutive annual cytology results and during follow up (ranging between 1-18 years) went on to have consistently normal cytology results. The median CD4 count of these women was 679 (IQR 450-889) cells/µl.
- 59 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 were low grade abnormalities 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)

Figure 1: Cytological abnormalities among WLWH

CD4 cell count (cells/µl)

Number of abnormalities in %

- 31 women had 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 those patients with an undetectable viral load and preserved CD4 count with three normal consecutive annual cytology results, longer intervals between cervical cytology screening may be appropriate. This would be cost saving for the department and reduce the number of outpatient appointments undertaken by WLWH. Further study is required, specifically to assess the significance of other risk factors for cervical abnormalities (e.g. smoking, hrHPV results) in this group.

Limitation

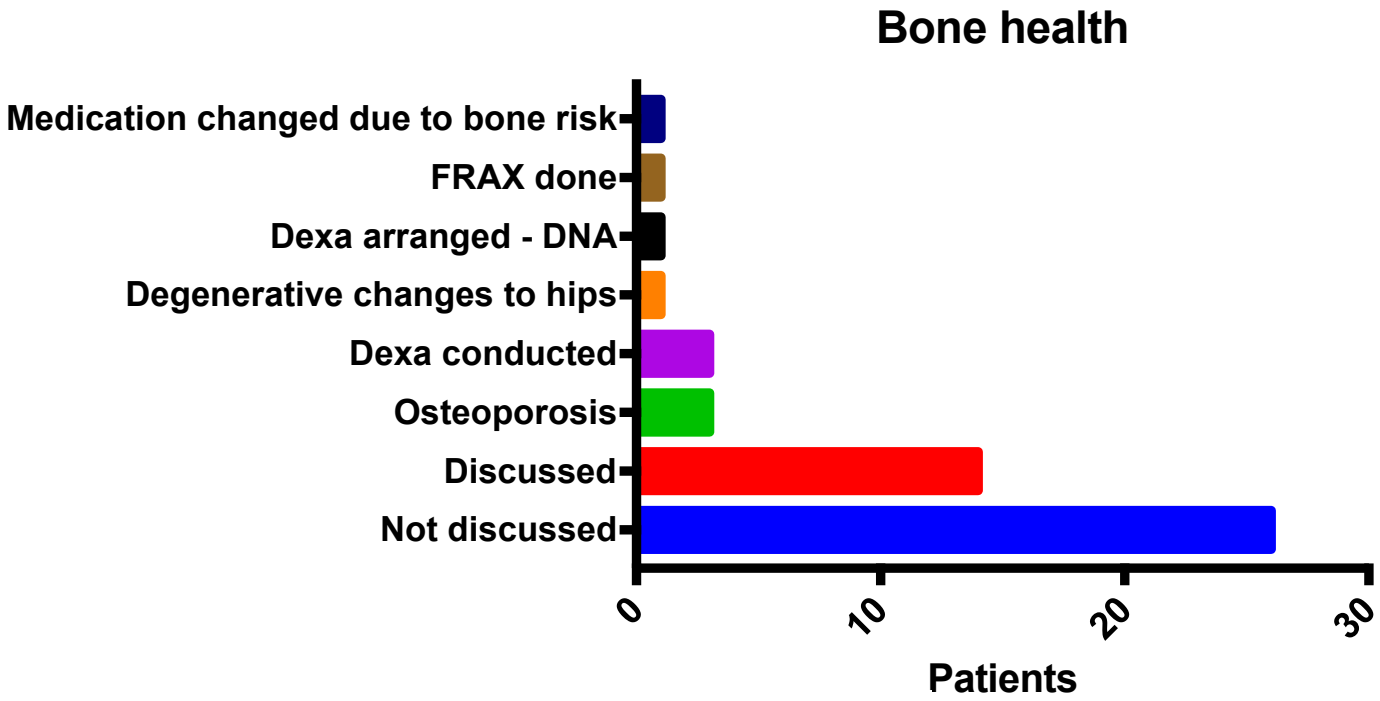
Retrospective study , small numbers of patients, lacking data on other risk factors for cervical abnormalities such as hrHPV data and smoking.

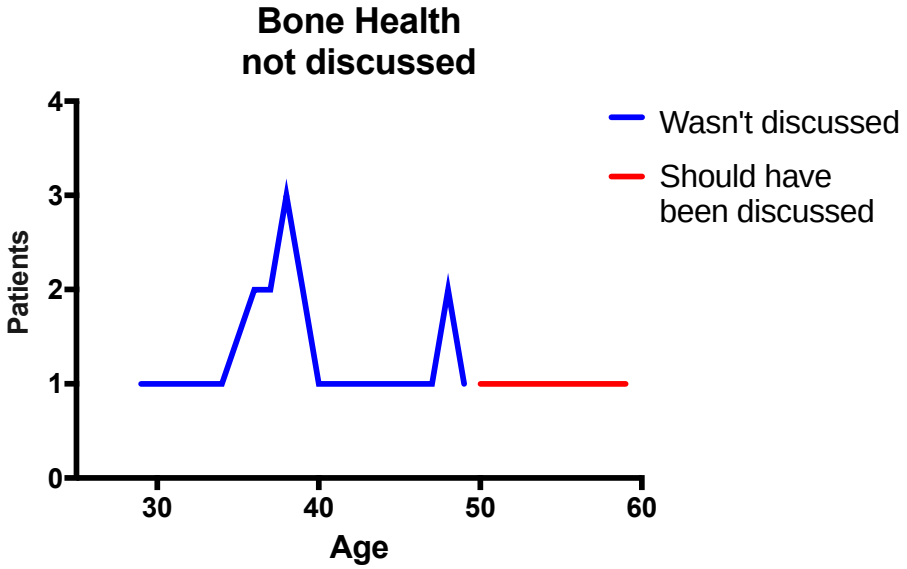
KING'S HEALTH PARTNERS

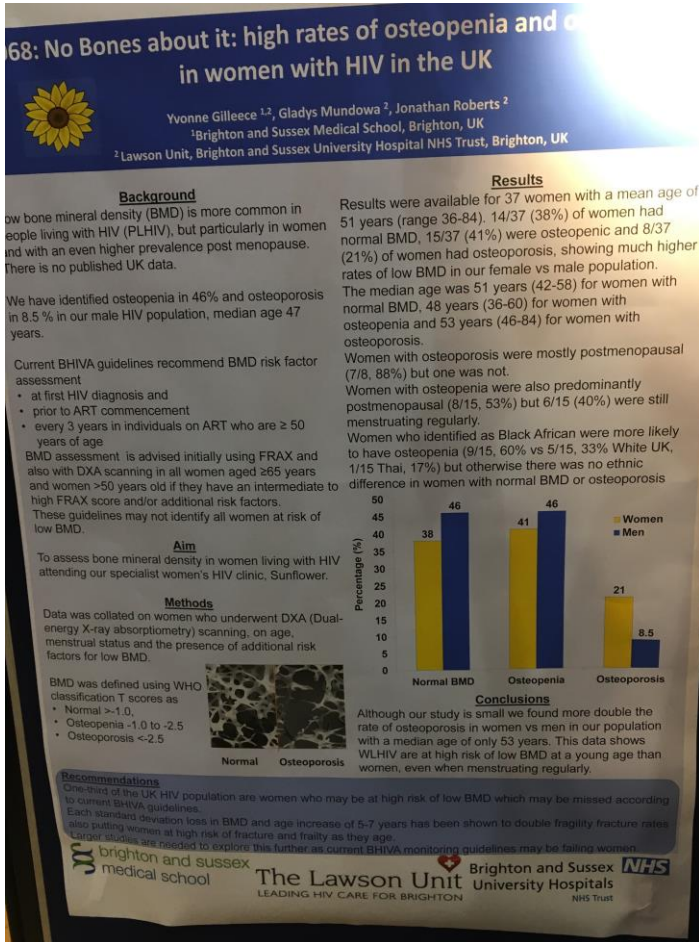
BSCCP – 5% of patients will have an abnormal cytology result

CRI data – 11% of patients had clinically abnormal

BONE HEALTH


Bone health
Medication changed due to bone risk
FRAX done
Dexa arranged - DNA
Degenerative changes to hips
Dexa conducted
Osteoporosis
Discussed
Not discussed
0
10
20
30
Patients


Bone Health
not discussed
Wasn't discussed
Should have
been discussed
Patients
0
1
2
3
4
30
40
50
60
Age


68: No Bones about it: high rates of osteopenia and
in women with HIV in the UK
Yvonne Gilleece [1,2], Gladys Mundowa [2], Jonathan Roberts [2]
[1]Brighton and Sussex Medical School, Brighton, UK
[2]Lawson Unit, Brighton and Sussex University Hospital NHS Trust, Brighton, UK
Background
Aim
Methods
Results
Conclusions
Recommendations
Normal BMD
Osteopenia
Osteoporosis
Women
Men
brighton and sussex medical school
The Lawson Unit
LEADING HIV CARE FOR BRIGHTON
Brighton and Sussex University Hospitals NHS Trust

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

I ♥ S THE 'DIFF

THANKS TO:-