HIVPA Bulletin | Summer 2024

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Welcome to the summer bulletin!

Hello all, this issue is packed to the brim with all the latest information and highlights from both the BHIVA and CHIVA conferences. It has been tough picking our conference highlights for this issue! Please remember that if you would like to showcase something you or your team have been doing, get in touch so we can share it across the network.

I am also pleased to announce a new member of the HIVPA bulletin team: Derick Ngai who has kindly included his bio below!

We would like to thank all those that have contributed and hope you enjoy the content, and invite you to share your thoughts with us on the HIVPA bulletin. If you have any feedback or want us to include anything in a future issue, please email: bhavna.halai@nhs.net – happy reading!

Derick Ngai – co-bulletin lead

Hello, I am a specialist pharmacist in HIV/Sexual Health at Guys and St Thomas NHS Foundation Trust. I enjoy working within the HIV specialty as pharmacists are highly integrated within the MDT. I am also keen on undertaking projects to improve service and practice. Therefore, as the bulletin co-lead, I hope to share the latest work, research and practice within the profession and promote collaboration between centres.

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News and events

HIV prevention 2025 roadmap

This PrEP roadmap is a welcomed step by the government to support the healthcare system to improve access, uptake and use of PrEP for key population groups. Key to this includes upskilling the workforce, improving pathways in settings that prescribe PrEP and raising awareness of PrEP in key population groups. The roadmap comes in time of much need for the UK as the inequality of PrEP access has been heavily publicised. The five key action areas are:

1. Funding of sexual health services and HIV PrEP though the public health grant (PHG).
2. Tackling inequalities in PrEP access, uptake and use.
3. Prompting awareness of PrEP amongst key groups.
4. Improving access pathways in specialist sexual health services.
5. Improving access to pathways in other settings.

For more information on the roadmap click here.

The HIV national service specification

NHS England has published a specialised adult inpatient and outpatient HIV service specification, aiming to ensure specialist assessment and ongoing management of HIV and associated conditions to support individuals to stay well, remain engaged in care and to reduce onward transmission.

Given the disparities in access to care for those from diverse backgrounds, the new service specifications act to maximise outcomes, wellbeing and quality of life, as well as put patients at the centre of care decisions. The service specification outlines outcomes and objectives for both inpatient and outpatient care including provision of care in prisons, custody and immigration retention centres. Core to the service specification is; collaborative health and social care, strategies to identify those not accessing care and tackling stigma. To find more information click here.

Dates for your diary

BASHH annual conference – 17th June 2024 Bournemouth · ANNUAL CONFERENCE 2024 | British Association for Sexual Health and HIV (bashh.org)

AIDS 2024 conference – 22-26th July 2024 Munich, Germany and virtual – AIDS the 25th International AIDS Conference

HIV Drug therapy Glasgow 2024 – 10th -13th November 2024 Glasgow, Scotland – HIV Drug therapy conference 2024

University of Liverpool HIV drug interaction checker – Drug update for flucloxacillin

The prescribing resource for flucloxacillin has been updated to show flucloxacillin as a weak, not moderate, enzyme inducer. For further information about enzyme induction by flucloxacillin, click here.

News and events

HIV testing amongst heterosexual men and women still less than pre-COVID

UKHSA data has revealed HIV testing rates amongst heterosexual men and women are down by a quarter compared to rates prior to the pandemic. Testing rates amongst heterosexual women via sexual health services are 19% lower than those in 2019, and heterosexual men are 33% lower. Find out more here.

BHIVA rapid guidance on the use of statins for primary prevention of cardiovascular disease in people living with HIV

BHIVA have responded to feedback received from the network by amending their guidance on statin usage following the findings of the REPRIEVE study. Noteworthy updates include:

- BHIVA does not recommend routine imaging as part of CVD risk assessment for primary prevention.
- Women planning to conceive should not be initiated on statins, and those that fall pregnant should have statins discontinued and not restarted until cessation of breastfeeding, where applicable.

For further information can be found here.

BHIVA publishes opt-out testing rapid guidance

With the rapid expansion of opt-out HIV testing in emergency departments, the BHIVA interim guidance is intended to assist emergency departments in high prevalence areas. The guidance has a summary of recommendations ranging from the practical implementation of the service, to publicity and training of staff. Find more information here.

University of Liverpool HIV drug interactions – new Apixaban prescribing resource

This new prescribing resource outlines the interactions and use of apixaban with strong CYP3A4 and P-gp inhibitors. The resource includes dose adjustment recommendations based on indications when used with strong CYP3A4 and P-gp inhibitors. For further information click here.

FSRH update: guidelines for the Mirena coil duration

The MHRA has approved an extension to the Mirena license from 5 years to 8 years for contraception. Note the extension does not apply for any other indications (including for endometrial protection as part of HRT (5 years from time of insertion) or to existing guidance about duration of use of Mirena for heavy menstrual bleeding). Those that already have a Mirena coil in situ can continue to with the same device 8 years (previously it was 6 years). For further information click here.

BHIVA conference highlights

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Dr Stuart Flanagan
Consultant HIV/hepatitis/GUM
Central and North West
London NHS Foundation Trust

Guidelines update

- **BHIVA Pulmonary Opportunistic Infection (OI) Guidelines March 2024**. Pulmonary cryptococcosis – aligned with WHO/ECMM/ISHAM guidance for fluconazole 1200mg dose. However, where antigen level is moderate-high, liposomal amphotericin B should still be used as first-line option.
- High dose fluconazole when antigen level is lower (i.e. < 1:160 by enzyme immunoassay).
- **BHIVA Pyrexia of unknown origin (PUO) Guidance update**: flowchart on investigation for HIV-associated PUO.

BHIVA Management of HIV in pregnancy and postpartum

- Preferred ART to start in pregnancy: TDF/FTC or TAF/FTC or ABC/3TC + DTG.
- Postnatal prophylaxis: Low risk 2 weeks Zidovudine (AZT) monotherapy; high risk combination therapy AZT/3TC + nevirapine (NVP) for 4 weeks.
- Infant feeding: U=U does not apply to breast/chest feeding. Risk of transmission is greatly reduced by antiretroviral therapy (ART) but is not zero.

Dr Laura Byrne
Consultant in HIV Medicine
St George's University Hospitals
NHS Foundation Trust

Dr Kyle Ring
Sexual Health & HIV Consultant
Barts Health NHS Trust

SHARE LAI-net

- Service evaluation to assess long acting cabotegravir and rilpivirine (CAB+RPV) processes and pathways, adherence to national guidelines and management of viremia across 12 UK HIV clinics.
- Reasons for switch to long acting injectables (LAI) according to healthcare professionals in descending order: inconvenience of oral pills, stigma, fear of disclosure, travel, drug-drug interactions (DDIs).
- N = 433. 25 (6%) discontinued; 3 (0.7%) experienced virological failure (VL ≥200c/mL). Of which, 1/3 acquired resistance at VF – NNRTI RAM K101E.

BHIVA conference highlights

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Dr Rachel Hill-Tout
Clinical Lead HIV ED opt-out testing
NHS England

Blood-borne virus (BBV) Testing – Expansion. Challenges and lessons of combined BBV approach

- National programme for emergency department (ED) opt-out BBV testing – 34 EDs in highest HIV prevalence areas: London (28), Manchester (3), Salford, Blackpool and Brighton.
- Results at 24 months: new diagnosis of HIV (741), HBV (2841), HCV RNA+ (1092); previously diagnosed, not in care for HIV (424), HBV (533), HCV RNA+ (216).
- Highest positivity rates seen for HBV. Ratio of new diagnoses: HIV (1): HBV (4): HCV (1.5).
- Spread and expansion: opt out ED BBV testing funding for 47 new sites in high HIV prevalence areas.

Addressing health inequalities experienced by Black African and Caribbean women in Birmingham: a collaborative approach

- Significant health disparities: higher rates of late HIV diagnosis, high risk of maternal mortality, mental health issues.
- Underlying factors to not accessing healthcare: intergenerational trauma (anxiety, hyperawareness, aversion towards healthcare professionals); social & economic factors (income and employment, poor housing).
- Birmingham Health and Wellbeing Board recognised these inequalities and is committed to tackling them. Established the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) to identify specific challenges and solutions.

Jara Phattey
Lead Health Advisor
Umbrella Sexual Health

Dr Nicola Mackie
Consultant in HIV/GUM
Imperial College Healthcare Trust

Management of low-level viremia

- Low-level viremia (LLV): a confirmed viral load between 50 and 200 copies/mL (BHIVA, US definition; WHO: 50 to 1000 copies/mL).
- Management of LLV: assess adherence, review drug-drug/drug-food interactions, consider tolerability issues, genotypic analysis for drug resistance.
- In the absence of resistance and if person fully adherent to treatment, consider non-suppressible viremia due to cellular proliferation.

BHIVA conference highlights

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Flavien Coukan
MSc PhD Imperial College London

Barriers and facilitators to PrEP access in Black women in England: perspective from multiple stakeholders

- Black women were shown to be some of the most under-represented key populations in England.
- Completed 3 focus groups across 3 streams of stakeholders: black women themselves, healthcare professionals and mixed of both.
- Six thematised barriers identified: information and knowledge gaps, restrictive policies and services, suboptimal PrEP use, distrust of healthcare system, relationship and gender challenges, cultural attitudes and stigma.
  Current progress: partnering with community organisation to address social determinants of health, advocating for policies that address systemic inequalities, collecting and analysing data to understand and track progress on addressing racial disparities.

What's new in general medicine?

- General medicine: investigations for hypertension to include urine dip, UACR, HbA1c, U&E, lipid profile, fundoscopy, ECG.
- Asthma update in Global Initiative Asthma guidelines for maintenance and reliever therapy (MART). Therefore, expect new BTS/SIGN guidance in asthma and potentially more DDIs.

Dr Michael Ewens
Consultant in HIV, Sexual Health & Internal Medicine
Leeds Teaching Hospitals NHS Trust

Prof Matt Phillips
GUM Consultant (Cumbria) & BASHH President

What's new in sexual health?

- Highest rates of gonorrhoea and syphilis since discovery of antibiotics.
- Increasing disparities in HIV testing amongst eligible heterosexual and bisexual women. Increased first diagnoses in ethnic groups other than white (black African, Asian, mixed or other ethnicity).
- Decreasing single point of access, access to health advisors. Limited access to MPox immunisations, TAF PrEP, doxy PEP.
- New drug and technology: 4CMenB vaccine (32.7 to 42% effective against gonorrhoea (GC)); question use of fluoroquinolones in mycoplasma genitalium with new MHRA alert; doxycycline post exposure prophylaxis (d-PEP) reduces incidence of GC (RR 0.45), early syphilis (RR 0.13), CT (RR 0.12).

CHIVA updates

CHIVA conference 2024

The CHIVA conference took place in March and summaries from some of the key sessions at the conference can be found on the news page on the CHIVA Website.

A session about Long-acting injectable antiretroviral therapy (LAI-ART) included a talk from the chair of the National HIV Nurses Association (NHIVNA) which focused on the practical implications of LAI-ART, stating that eligible patients stand to benefit from improved adherence owing to reduced pill burden, extended dosing intervals, and potentially enhanced viral suppression. The session also included an interview between a Clinic Nurse Practitioner and her patient - a young person living with HIV, who shared their personal experience of LAI-ART. The session provided a good overview of how health professionals can strike a balance between benefits and challenge of LAI-ART. Read more.

Posters presented at the conference can also be found here.

CHIVA's new medicine resources

CHIVA has launched a new set of resources about HIV medication which pharmacists can use in their work with young people living with HIV. These are appropriate for young people or young adults who may need a bit of extra information, for example with coping with side effects of their medication or understanding how contraceptives can interact with HIV medication.

CHIVA worked with health experts, a group of young people living with HIV and Aidsmap to produce these new resources which are designed to help support young people to take their medication.

Check them out here and please contact Bo.Borthwick@chiva.org.uk to request hard copies for free.

Enhancing HIV Care Provision: Scalability of Pharmacist-led Care

S Leung, H Mirza, Y Daramola, A Hicks, R Byrne, M Boffito, N Naous
Chelsea and Westminster Hospital NHS Foundation Trust

Introduction

- With declining healthcare budgets and numbers of HIV medical trainees [1], workforce innovation is crucial to sustain delivery of HIV care.
- Since local introduction of an advanced pharmacist practitioner (APP) role [2], we have demonstrated the ability of pharmacists to provide holistic care to people living with HIV, including those with complex medical needs.
- Scaling up pharmacist-led care may be a potential solution to sustain service delivery [3] whilst addressing the needs of an ageing cohort [4, 5, 6].
- Further APP clinics were introduced with consultant support and supervision. We aim to evaluate the impact and outcomes of these clinics.

Method

- Prospective data collection of consultations conducted by four pharmacist practitioners (PP) across four HIV clinics between January to December 2023.
- Surveys were distributed after the appointment to capture service users' opinions on the pharmacists' role and care provided.

Results

634 consultations (513 individuals) within 170 clinical sessions during 12-month period (fig. 1):
585 (92%) in person, 50 (8%) telephone appointment

Demographics of people living with HIV seen:

- 176 (34%) female, 337 (66%) male
- 204 (40%) White, 168 (32%) Black, 46 (9%) Asian, 19 (4%) Mixed, 76 (15%) other/not stated
- Median age: 52 (IQR: 43-58)
- 87% virologically suppressed (VL<50)

Mean no. of co-morbidities: 2 (0-8)

87 (17%) had >5 co-medications (0-21)

Figure 1: Proportion of consultations in 3 clinics

Clinic	No. of people seen	Percentage of entire clinic cohort seen	No. of clinical sessions
Clinic A	247	52%	101
Clinic B	240	6%	59
Clinic C	26	6%	10

Figure 2: Interventions and Investigations made by PPs

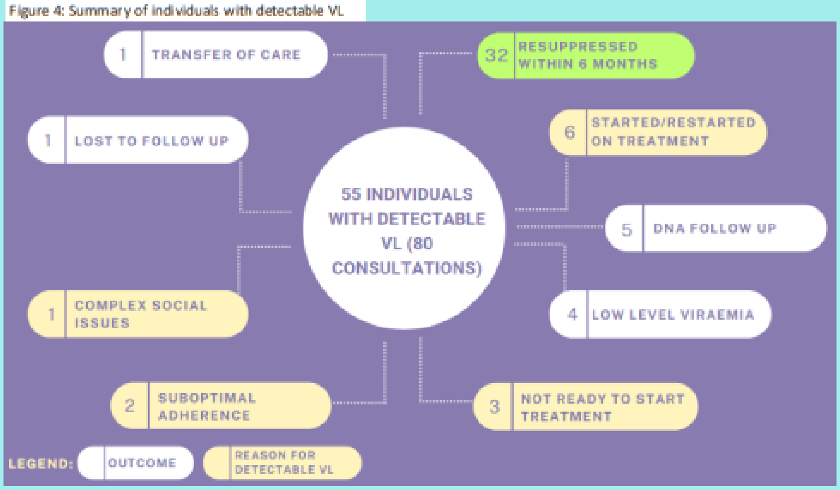
Intervention & Investigations	n
Referral to other specialities (e.g. dietitian, mental health services)	147
Imaging requested (e.g. DEXA, CT CACS, liver US)	112
Vaccine prescribed (e.g. Hep A/B, HPV, Mpox)	103
Initiation or switch of ARVs	99
Medicines optimisation (e.g. initiate/titrate non-ARVs, deprescribing)	61

Following investigations, 44 new medical conditions identified and managed by the PPs (fig. 3)

Figure 3: New medical conditions identified and managed by PPs

New medical conditions identified	n
Micronutrient deficiency	18
Skin conditions	8
Metabolic disorder	6
Osteoporosis	3
Others	9

Figure 4: Summary of individuals with detectable VL



Survey results

- A total of 55 service users responded to the survey
- 30 (55%) aware that pharmacists could review their overall health
- All (100%) felt quality of care received met or exceeded expectations
- 54 (98%) would be open to attend a pharmacist-led appointment in future

Conclusions

- We have previously successfully demonstrated implementation of pharmacist practitioner clinics as a novel way of utilising and developing the pharmacist workforce.
- We demonstrate scalability of this service delivery model in our large, urban multi-site centre by successfully increasing the number of pharmacist practitioner clinics from three clinics to six clinics week.
- The positive feedback from service users indicates high acceptability of this model.
- HIV services may consider investment into mobilising senior pharmacists to facilitate expansion of this advanced practitioner role in order to address increasing levels of co-morbidities, polypharmacy and complex medical needs observed in our ageing population.
- The knowledge base of HIV pharmacists means they are ideally placed to facilitate communication across sectors, specialties and disciplines.
- Future development plans include expanding to other specialist areas such as PrEP, contraception, gender health and research delivery and enhanced skills such as phlebotomy, injectable ART administration.

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Injectable antiretroviral treatment for HIV at Leeds Teaching hospital experience so far

Dr Katie Drury[1], Anna-Luisa Simonini[1], Emma Wrench[1], Dr Sarah Schoeman[1], Dr Emma Page[1]
1 Leeds Teaching Hospitals NHS Trust

The Leeds Teaching Hospitals NHS Trust

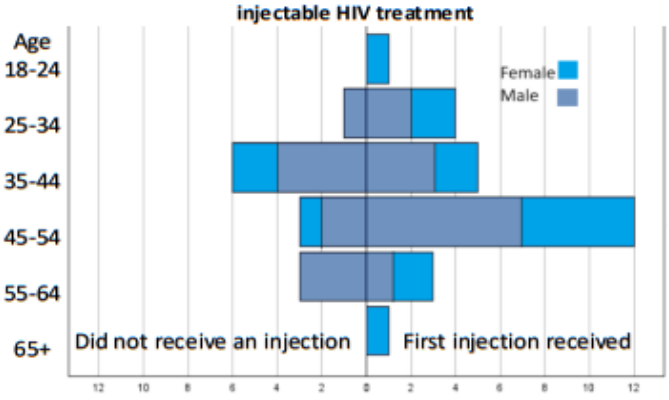
Introduction From April 2022 injectable therapy for people living with HIV became available on the NHS. With the initial roll out BHIVA recommended a cautious approach due to: lack of real-world data, the consequences of virological failure (dual-class resistance) and the requirement to create clinic capacity for twice monthly appointments. Services were to focus on those most in need: expressing major psychological barriers to pill taking, inability to take oral medication, concerning adherence while virally suppressed or describing a risk of stopping oral ART.

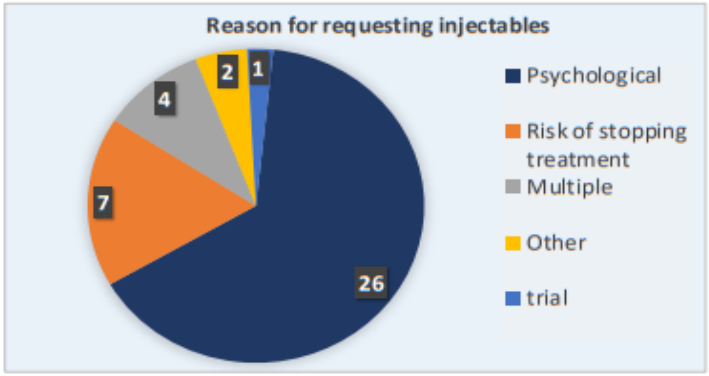
We report real-world data from Leeds Teaching Hospitals Trust (LTHT)

Methods Leeds Teaching Hospitals Trust (LTHT) required all people considered for injectables to be discussed at the HIV Virology MDT to ensure injectables were clinically appropriate and met 'most in need' criteria. We reviewed notes of all people approved to commence injectable therapy from April 2022 to the current time. We report our unit's real-world data.

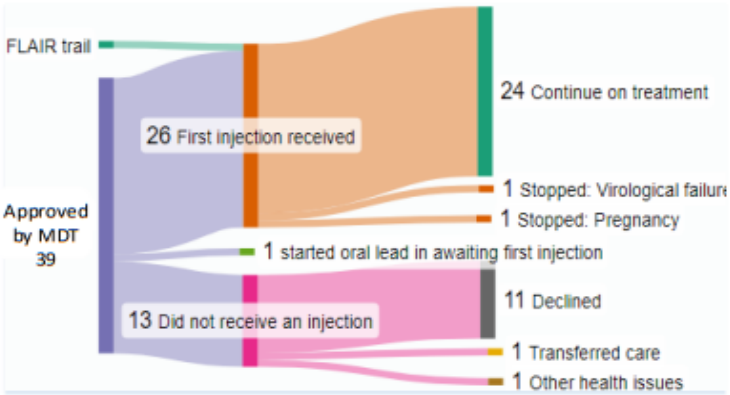
RESULTS

Age and gender distribution of those people approved by MDT for injectable HIV treatment





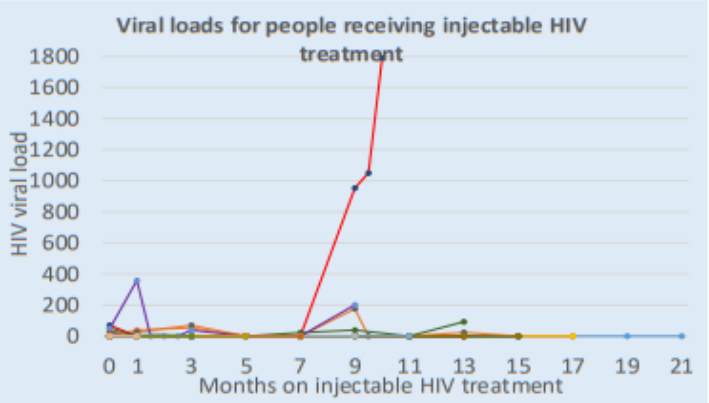
Sankey diagram showing patient approved for injectable treatment



Outcomes. 25 people were administered an initial injection. 1 continued from the FLAIR trial. Of 26 people commenced on injectables the median duration of treatment is 12.95 months (IQR 9.74 – 15.74). The median BMI was 26.60 (IQR 22.09 to 28.75. The most frequent serotypes were B (11) and C(8). 2 people have stopped injectables, 1 due to virological failure and 1 due to pregnancy.

Virological blips Two people experienced virological blips. One person had a viral load of 70 copies/ml at 3 months and 176 copies/ml at 9 months. They have since remained suppressed for 8 months. One person had a viral load of 359 copies/ml at 2 months. This settled for 9 months but rose again to 200 copies/ml this month.

Virological failure One person discontinued due to virological failure. They had received 5 injections. On review they had no predictive reasons for failure. Viral load was 70 copies/ml on completing the oral lead in prior to the first injection. They were virologically suppressed (< 50 copies/ml) until the day of their last injection when their viral load was 953 copies/ml. A repeat sample 2 weeks later was 1,050 copies/ml. A decision was made to switch treatment to Symtuza. A viral load 6 weeks post switch is < 100 copies/ml. Resistance tests on first raised viral load demonstrated acquired mutations: NNRTI E138EK and INSTI GS140GS, Q148QKR, N155NH.



Pregnancy One person become pregnant around the time of their 8th injection. The case was discussed at the MDT. Evidence for Long-acting cabotegravir and rilpivirine injectable use in pregnancy is limited. Currently it should only be used during pregnancy when the potential benefits outweigh the risk (3). She was switched to Triumeq prior to when the next dose was due; around 12 weeks gestation. Monitoring continues in the HIV pregnancy MDT. Current viral load 398 copies/ml

Conclusion In our experience injectable therapy has been life transforming for many. However a third approved declined to start and 1/26 commenced developed virological failure with dual class resistance after just 5 injections. Since December and the incidence of virological failure only one patient has been approved for injectable HIV therapy and is currently receiving oral lead in. Someone who was due to start injectable treatment declined as they knew the person who had experienced virological failure.

REFERENCES

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