Survey of ART failure management

BHIVA Clinical Audit Sub-Committee:

M Backx, C Ball, G Brook, P Bunting, C Carne, A DeRuiter, K Foster, A Freedman, P Gupta, V Harindra, M Johnson, G McCourt, C O'Mahony, E Monteiro, E Ong, K Orton, R Pebody, A Rodger, C Sabin, R Weston, E Wilkins, D Wilson, M Yeomans

Aim and background

To describe arrangements for managing patients with HAART failure and/or drug resistance, and ways these might be improved.

Failure defined as persistently detectable VL on HAART:

- First line: first failure, with no or single-class resistance. May have had previous treatment change eg for toxicity/tolerability.
- Second or subsequent failure.

Methods and participation

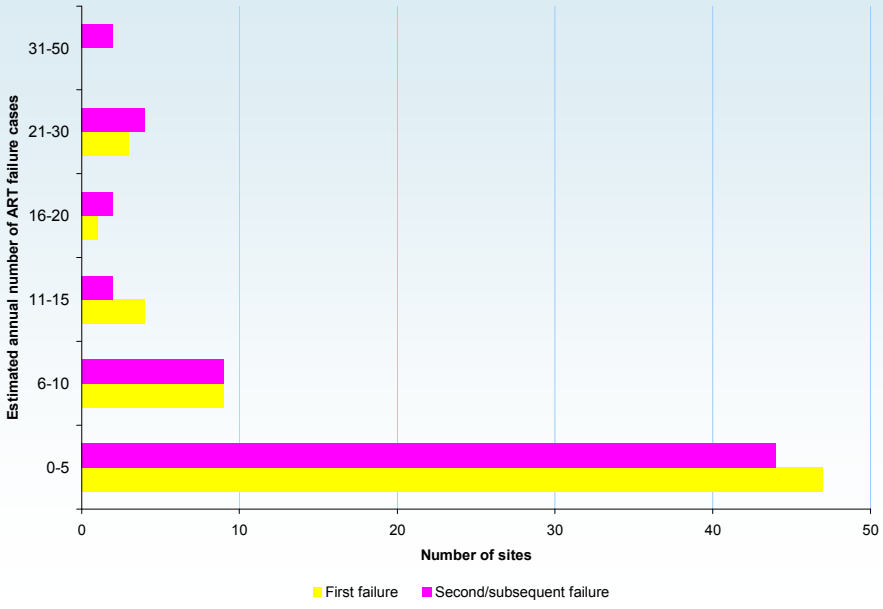
Online survey completed October 2008 – January 2009 by 70 sites providing adult HIV care.

53 had responded to a 2007 survey of clinical network arrangements. Based on this:

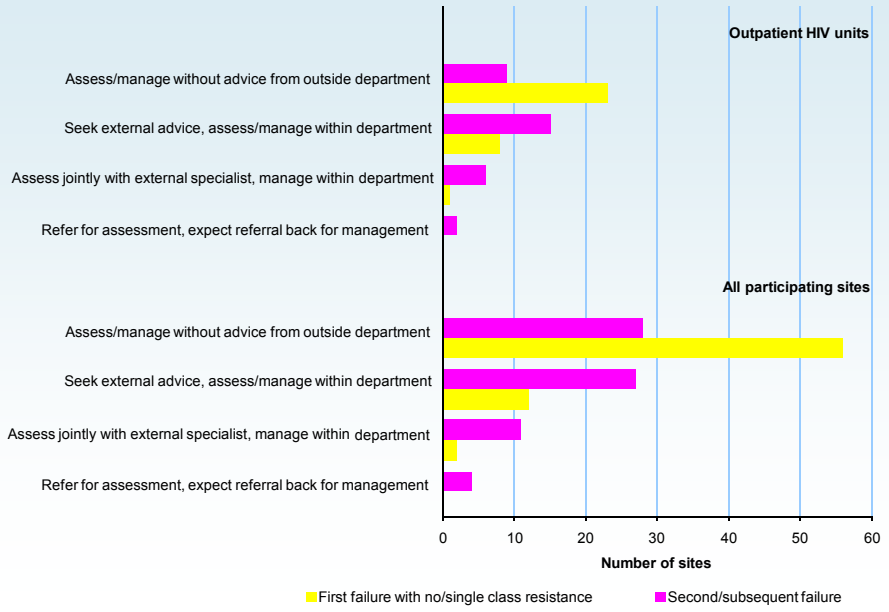
- 32 classified as outpatient HIV units
- 8 classified as HIV centres providing complex care.

The other 30 clinics/departments were not clearly classified.

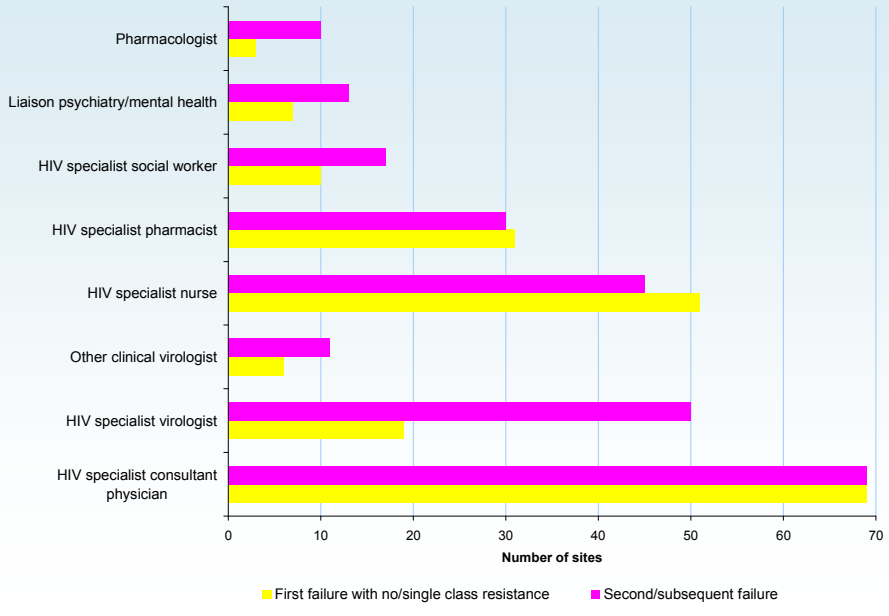
Sites' experience of ART failure



How is ART failure managed?



Multidisciplinary involvement



Assessment method for second/subsequent failure

- 44 sites use multidisciplinary meetings (2 with patient present)
- At 23 sites, the lead clinician consults individually with other relevant specialists
- No sites routinely use teleconference, online forums or other non-face to face discussion.

61 (87%) have a *regular* arrangement for multidisciplinary assessment of such patients – 38 at the site and 23 across the clinical network.

Other issues raised

- Several respondents wanted better access to expert advice, especially HIV specialist pharmacists and virologists. Also mental health specialists, HIV nurses, pharmacologists, social workers, dieticians.
- Direct personal interaction is important for multidisciplinary review of complex patients. Some respondents suggested more use could be made of teleconferences, online forums etc.
- Multi-disciplinary case discussions are valued for CPD as well as individual patient care.

Other issues raised, continued

- Problems with funding for specific drugs were rare.
- However, several sites reported problems with funding clinical networks, pharmacists, other staff, and mental health care. Some thought commissioning was unclear or poor.
- Most sites sometimes seek advice from *outside* their own clinical network; 3 do so monthly or more.

Conclusions

- ART failure occurs only rarely at most sites.
- It is mostly managed locally rather than through clinical networks.
- About a quarter of outpatient HIV units assess second/subsequent failure patients without seeking external specialist advice.
- There is scope for strengthening clinical networks and multidisciplinary engagement in assessing and managing ART failure and resistance.

Recommendation

- Clinicians and commissioners should continue to develop and support clinical networks for HIV in line with *Standards for HIV clinical care*.

Pandemic H1N1 influenza rapid appraisal

Online survey of BHIVA members to assess impact of pandemic H1N1 influenza on HIV patients and services. Initial issues:

- Avoiding mis-diagnosis: HIV patients with non-severe influenza symptoms to phone HIV clinic (as well as flu hotline/GP)
- Some clinics lack facilities to separate symptomatic outpatients from other patients
- Overall workload impact of epidemic.

To continue, focussing on HIV-related concerns.

BHIVA Audit & Standards Committee

Planned for autumn 2009:

- Casenote review and survey of HIV and hepatitis B/C co-infection
- Survey of management of paediatric aspects of adult HIV care:

  ensuring testing of children of adult patients

  transition for young people.