Fourth Joint Conference of the British HIV Association (BHIVA)
with the
British Association for Sexual Health and HIV (BASHH)
17–20 April 2018, Edinburgh International Conference Centre, UK

Conference Sponsors 2018

Tuesday 17 April 2018	
1530-1900	Registration desk and exhibition open
1630–1700	**Welcome Addresses by the Chair of the BHIVA and President of BASHH** Professor Chloe Orkin BHIVA Chair Dr Olwen Williams, OBE BASHH President
1700–1730	**BHIVA/BASHH Invited Lecture 1** **Modern malignancies in HIV and sexual health** Professor Mark Bower *Chelsea and Westminster Hospital, London*
1730–1830	**BHIVA/BASHH HIV Symposium** **Supporting marginalised populations in HIV care – clinical cases** **Managing transgender patients in HIV care** Dr Kate Nambiar *Brighton and Sussex Medical School* **Managing vulnerable women in HIV care** Professor Jane Anderson *Homerton University Hospital, London* **Managing HIV care for people from different ethnic backgrounds** Dr Rageshri Dhairyawan *Barts Health NHS Trust, London*

	Managing intravenous drug users in HIV care Dr Emma Thomson *University of Glasgow* *BHIVA and BASHH are grateful to ViiV Healthcare UK for supporting this symposium via an educational grant. ViiV Healthcare UK has no involvement in the content or participants of this session.*
1830–1900	**BHIVA/BASHH Keynote Lecture** **HIV cure strategies: interventions, endpoints and ethics** Professor Sharon Lewin *The Peter Doherty Institute for Infection and Immunity, Melbourne, Australia*
Wednesday 18 April 2018	
0800–1915	Registration desk and exhibition open
0900–1000	**Oral Research Presentations:** Session 1 (1–6)
1000–1100	**Janssen Satellite Symposium**
1100–1130	Morning Coffee
1130–1230	**BHIVA/BASHH Review Session** **Advances in HIV care for 2018** Professor Chloe Orkin *Barts Health NHS Trust, London* **Advances in sexual health for 2018** Dr Suneeta Soni *Royal Sussex County Hospital*, *Brighton* **Advances in general medicine for 2018** Dr Laura Waters *Mortimer Market Centre, London*
1230–1300	**BHIVA/BASHH Audit Session** **2018 Audit of HIV partner notification** Dr Lauren Bull *Chelsea and Westminster Hospital, London* **Case presentation: HIV partner notification** *Speaker tbc*
1300–1500	Lunch and Poster Presentations
1310–1355	**BHIVA/BASHH Lunchtime Workshop 1** **Blood-borne virus resistance: challenges in the modern era** Professor Ravi Gupta *University College London* Dr Sanjay Bhagani *Royal Free Hospital, London*
1310–1355	**BHIVA/BASHH Lunchtime Workshop 2** **Safeguarding in HIV and sexual health** Dr Jane Ashby *Mortimer Market Centre, London* Dr Margaret Kingston *Manchester Royal Infirmary*
1355–1455	**Gilead Sciences Lunchtime Workshop**
1355–1455	**MSD Lunchtime Workshop**
1500–1630	**Oral Research Presentations:** Session 2 (7–15)
1630–1700	Afternoon Tea
1700–1800	**MSD Satellite Symposium**

1800–1830	**BHIVA/BASHH Invited Lecture 2** **Health Protection Research Unit: blood-borne and sexually transmitted infections** **An introduction to the HPRU and our proposed strategy** Professor Caroline Sabin *University College London* **How can primary care work more closely with sexual health services to deliver appropriate testing, prevention and care for STIs and HIV** Professor Jackie Cassell *Brighton and Sussex Medical School* **Harnessing molecular technology to inform our understanding of HIV and STI epidemics** Ms Katy Town *National Institute for Health Research (NIHR)*
1830–1915	**BHIVA/BASHH Poster Session**
1915–2000	**Civic Welcome Reception** Lord Provost Professor Clifford Leen – BHIVA Local Host Dr Imali Fernando – BASHH Local Host
Thursday 19 April 2018	
0800–1830	Registration desk and exhibition open
0825-0855	**BHIVA Standards of Care Launch**
0900–1000	**BHIVA/BASHH Guidelines Session** **BHIVA/BASHH/BIS HIV testing guidelines** Dr Adrian Palfreeman *Leicester Royal Infirmary* **Joint FSRH/BASHH/BHIVA guidelines for sexual and reproductive health in people living with HIV** Dr Nicola Mackie *Imperial College Healthcare NHS Trust, London* **BASHH *Mycoplasma genitalium* guidelines** Dr Helen Fifer *Public Health England* **BASHH gonorrhoea guidelines** Dr Tariq Sadiq *St George's, University of London* **BHIVA pregnancy guidelines** Dr Yvonne Gilleece *Royal Sussex County Hospital*, *Brighton*
1000–1100	**Gilead Sciences Satellite Symposium**
1100–1130	Morning Coffee
1130–1300	**Oral Research Presentations:** Session 3 (16–24)
1130–1300	**Oral Research Presentations:** Session 4 (25–33)
1300–1500	Lunch and Poster Presentations
1310–1355	**BHIVA/BASHH Lunchtime Workshop 3** **Clinico-pathological case presentations workshop** Professor Mark Bower *Chelsea and Westminster Hospital, London* Dr Emma Devitt *Chelsea and Westminster Hospital, London* Dr Ula Mahadeva *Guy's and St Thomas' Hospital, London*

1310–1355	**BHIVA/BASHH Lunchtime Workshop 4** **Digital technologies, HIV and STIs** Professor Claudia Estcourt *Glasgow Caledonian University* Dr Jennifer Whetham *Royal Sussex County Hospital, Brighton*
1355–1455	**Gilead Sciences Lunchtime Workshop**
1355–1455	**Janssen Lunchtime Workshop**
1500–1600	**Oral Research Presentations:** Session 5 (34–39)
1500–1600	**Oral Research Presentations:** Session 6 (40–45)
1600–1630	Afternoon Tea
1630–1730	**ViiV Healthcare UK Satellite Symposium**
1730–1800	**BHIVA/BASHH Invited Lecture 3** **Telling the truth: issues around disclosure of sexually transmitted infections** Dr Andreas Wismeijer *Tilbury University*, *The Netherlands*
1945	**Gala Dinner**
Friday 20 April 2018	
0800–1630	Registration desk and exhibition open
0900–0930	**BHIVA/BASHH Invited Lecture 4** **Refugees, migrants and healthcare access: key issues in the response to HIV, STIs and TB** Dr Fionnuala Finnerty *Royal Sussex County Hospital, Brighton* Dr Yusef Azad *National AIDS Trust*
0930–1030	**Satellite Symposium**
1030–1100	Morning Coffee
1100–1200	**BHIVA/BASHH Clinical Conundrums Session** **Overheard at the gym: a clinician's overview of interactions/toxicities of commonly used drugs:** • **Non steroids** Dr Chris Ward *Manchester Royal Infirmary* • **Steroids** Mr Jim McVeigh *Liverpool John Moores University* **HIV and lumbar punctures in 2018** Dr Paul Holmes *St Thomas' Hospital, London*
1200–1230	**Oral Poster Presentations**
1230–1430	Lunch and Poster Presentations
1240–1325	**BHIVA/BASHH Lunchtime Workshop 5** **Young people with HIV: Challenges with transition** Dr Caroline Foster *Imperial College Healthcare NHS Trust, London* Dr Laura Jones *Royal Hospital for Children, Edinburgh*

1240–1325	**BHIVA/BASHH UK CAB Workshop** **Talking to patients about U=U** Dr Michael Brady *Kings College Hospital, London* Mr Marc Thompson *UK Community Advisory Board*
1325–1425	**ViiV Healthcare UK Lunchtime Workshop**
1325–1425	**Sponsors Lunchtime Workshop (TBC)**
1430–1445	**Prizes and Awards Ceremony (BHIVA and BASHH Chairs)**
1445–1515	**BHIVA/BASHH Invited Lecture 5** **Identity, culture and wellbeing among MSM: a model for enhancing clinical practice** Professor Rusi Jaspal *De Montfort University, Leicester*
1515–1630	**BHIVA/BASHH Plenary Session** **PrEP question time** **Facilitators/interviewers** Dr Mark Pakianathan, *St George's Hospital, London* **England** Dr John Saunders *Public Health England* **Wales** Dr Olwen Williams, OBE *Wrexham Maelor Hospital* **Scotland** Dr Rak Nandwani *NHS Greater Glasgow and Clyde* **Northern Ireland** Dr Carol Emerson *Belfast Health and Social Care Trust* **Ireland** Dr Fiona Lyons *St. James's Hospital, Dublin, Ireland* **The global perspective** Professor Martin Markowitz *The Aaron Diamond AIDS Research Center, New York, USA*
1630	**Close** Professor Chloe Orkin BHIVA Chair Dr Olwen Williams, OBE BASHH President

Symtuza®

(darunavir/cobicistat/emtricitabine/tenofovir alafenamide) tablets
800mg/150mg/200mg/10mg

single pill sustained efficacy at 48 weeks[1,2]

The first PI-based single tablet regimen for HIV-1 patients

At 48 weeks:

High virologic suppression*

- 94.9% for treatment-experienced patients**,[1]
- 91.4% for treatment-naïve patients†,[2]

No resistance to any study drug detected for treatment-experienced patients[1]

- No development of darunavir, primary PI or TDF/TAF▼ resistance in treatment-naive patients††,[2]

Bone and renal safety consistent with known profiles of TAF▼ and cobicistat▼[1,2]

To find out more about what Symtuza has to offer, speak to one of our Account Managers at the Janssen stand and join our lunchtime workshop taking place on the 19th April from 13:55 - 14:55.

SYMTUZA is indicated for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in adults and adolescents (ages 12 years and older with body weight at least 40 kg).[3]

Genotypic testing should guide the use of Symtuza.[3]
Please see the Symtuza Summary of Product Characteristics for further advice.

janssen Infectious Diseases
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

SYMTUZA® ▼ 800 mg/150 mg/200 mg/10 mg film-coated tablets PRESCRIBING INFORMATION. ACTIVE INGREDIENT(S): darunavir, cobicistat, emtricitabine, tenofovir alafenamide. Please refer to Summary of Product Characteristics (SmPC) before prescribing. **INDICATION(S):** Treatment of human immunodeficiency virus type 1 (HIV 1) infection in adults and adolescents (aged 12 years and older with body weight at least 40 kg). Genotypic testing should guide use. **DOSAGE & ADMINISTRATION:** Initiate by physician experienced in management of HIV 1 infection. **Adults and adolescents aged ≥ 12 years weighing ≥ 40 kg:** one tablet daily with food in ART-naïve patients. *ART-experienced patients:* one tablet daily with food if no darunavir resistance associated mutations (DRV-RAMs) and plasma HIV-1 RNA < 100,000 copies/ml and CD4+ cell count ≥ 100 cells x 10^6/l. If dose > 12 hours late, do not take missed dose and resume usual dosing schedule. **Children:** Not established in children aged 3-11 years, or weighing < 40 kg. No data available. Should not be used below 3 years of age. **Elderly:** Limited information; use with caution in patients > 65 years of age. **Renal impairment:** $eGFR_{CG}$ ≥ 30 ml/min: no dose adjustment. $eGFR_{CG}$ < 30 ml/min: do not start/discontinue treatment as no data. **Hepatic impairment:** mild (Child-Pugh Class A)/moderate (Child-Pugh Class B) hepatic impairment: no dose adjustment; use with caution. Severe hepatic impairment (Child-Pugh Class C): not studied; do not use. **CONTRAINDICATIONS:** Hypersensitivity to active substances/excipients. Severe (Child-Pugh Class C) hepatic impairment. Co-administration with carbamazepine, phenobarbital, phenytoin, rifampicin, lopinavir/ritonavir, St. John's wort (*Hypericum perforatum*), alfuzosin, amiodarone, dronedarone, quinidine, ranolazine, colchicine (with renal and/or hepatic impairment), ergot derivatives (e.g. dihydroergotamine, ergometrine, ergotamine, methylergonovine), pimozide, quetiapine, sertindole, lurasidone, triazolam, midazolam administered orally, sildenafil (for treatment of pulmonary arterial hypertension), avanafil, simvastatin, lovastatin, ticagrelor. **SPECIAL WARNINGS & PRECAUTIONS:** Take precautions to prevent viral transmission. ***ART-experienced patients:*** not for treatment-experienced patients with one or more DRV-RAMs or with HIV-1 RNA ≥ 100,000 copies/ml or CD4+ cell count < 100 cells x 10^6/l. ***Co-infection with hepatitis B/C virus:*** increased risk for severe, potentially fatal hepatic adverse reactions. Safety/efficacy not established when co-infection with HIV-1 and hepatitis C virus (HCV). Tenofovir alafenamide active against HBV. Discontinuation of Symtuza may result in severe acute exacerbations of hepatitis if co-infection with HBV; monitor closely (clinical/laboratory follow-up for at least several months after stopping Symtuza). With advanced liver disease or cirrhosis, discontinuation not recommended; post-treatment exacerbation of hepatitis may lead to hepatic decompensation. Do not use concomitantly with medicinal products containing tenofovir disoproxil (e.g. fumarate, phosphate, succinate), lamivudine, or adefovir dipivoxil (for HBV). ***Mitochondrial dysfunction:*** mitochondrial dysfunction reported in HIV negative infants exposed *in utero* and/or postnatally to nucleoside analogues. Main adverse reactions (often transitory) are haematological disorders (anaemia, neutropenia) and metabolic disorders (hyperlactataemia, hyperlipasaemia). Late-onset neurological disorders have been reported (hypertonia, convulsion, abnormal behaviour); not known if transient or permanent. Follow up/investigate any child exposed *in utero.* Follow current national recommendations for pregnant women. ***Hepatotoxicity:*** Drug-induced hepatitis reported with darunavir/ritonavir. Increased if pre-existing liver dysfunction, including severe/potentially fatal hepatic adverse reactions. If concomitant antiviral therapy for hepatitis B or C, refer to relevant SmPCs. Conduct laboratory tests prior to initiating therapy; monitor during treatment. Consider increased AST/ALT monitoring with underlying chronic hepatitis, cirrhosis, pre-treatment transaminase elevations, especially during first months. Consider prompt interruption/discontinuation of Symtuza if evidence of new/worsening liver dysfunction. ***Nephrotoxicity:*** potential risk from chronic exposure to low levels of tenofovir alafenamide. ***Renal impairment:*** Cobicistat decreases estimated creatinine clearance. ***Haemophilia:*** reports of increased bleeding. ***Severe skin reactions:*** Discontinue Symtuza immediately if signs/symptoms of severe skin reactions. Drug Rash with Eosinophilia and Systemic Symptoms (DRESS), Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN) and acute generalised exanthematous pustulosis reported with darunavir/ritonavir. ***Sulphonamide allergy:*** caution; contains sulphonamide moiety. ***Immune Reactivation Syndrome (IRIS):*** Inflammatory response to asymptomatic or residual opportunistic pathogens may arise in patients with severe immune deficiency at start of combination antiretroviral therapy (CART); evaluate symptoms when necessary. Herpes simplex/zoster reactivation observed with darunavir/ritonavir. Autoimmune disorders reported. ***Opportunistic infections:*** can develop; close clinical observation required. ***Other:*** Increase in weight, levels of blood lipids and glucose may occur, monitor blood lipids and glucose; refer to HIV treatment guidelines. Do not use Symtuza in combination with another antiretroviral requiring pharmaco-enhancement, with ritonavir, cobicistat, tenofovir disoproxil (as fumarate, phosphate or succinate), lamivudine or adefovir dipivoxil. **SIDE EFFECTS: Very common:** headache, diarrhoea, nausea, rash (including macular, maculopapular, papular, erythematous, pruritic rash, generalised rash, and allergic dermatitis), fatigue. **Common:** hypersensitivity, anorexia, diabetes mellitus, hypercholesterolaemia, hypertriglyceridaemia, hyperlipidaemia, abnormal dreams, dizziness, vomiting, abdominal pain, abdominal distension, dyspepsia, flatulence, pancreatic enzymes increased, hepatic enzyme increased, angioedema, pruritus, urticaria, arthralgia, myalgia, asthenia, increased blood creatinine. **Other side effects:** IRIS, pancreatitis acute, acute hepatitis, cytolytic hepatitis, DRESS, SJS, TEN, acute generalised exanthematous pustulosis, osteonecrosis. **Refer to SmPC for other side effects. PREGNANCY:** Use only if potential benefit justifies potential risk. **LACTATION:** HIV infected women must not breast-feed under any circumstances. **INTERACTIONS:** Symtuza not studied; interactions identified in studies with individual components. Refer to the SmPC for full details before initiating therapy. See contraindications above. ***Do not use:*** voriconazole (unless positive benefit risk ratio). ***Not recommended:*** rifabutin, rifapentine, oxcarbazepine, efavirenz, bosentan, boceprevir, telaprevir, apixaban, dabigatran etexilate, rivaroxaban, everolimus, budesonide, fluticasone, simeprevir, salmeterol, tadalafil (for pulmonary arterial hypertension). ***Use with caution:*** systemic dexamethasone, clarithromycin, artemether/lumefantrine, dasatinib, nilotinib, vinblastine, vincristine, sildenafil, vardenafil, tadalafil (erectile dysfunction). ***Therapeutic drug monitoring advised:*** disopyramide, flecainide, mexiletine, propafenone, systemic lidocaine, ciclosporin, sirolimus, tacrolimus. ***Clinical monitoring recommended &/or dose adjustment:*** alfentanil, digoxin, warfarin (monitor INR), paroxetine, sertraline, amitriptyline, desipramine, imipramine, nortriptyline, trazodone, metformin, clotrimazole, fluconazole, itraconazole, ketoconazole, isavuconazole, posaconazole, colchicine (patients with normal renal/hepatic function), perphenazine, risperidone, thioridazine, carvedilol, metoprolol, timolol, amlodipine, diltiazem, felodipine, nicardipine, nifedipine, verapamil, prednisone, atorvastatin, fluvastatin, pitavastatin, pravastatin, rosuvastatin, methadone, buprenorphine/naloxone, fentanyl, oxycodone, tramadol, buspirone, clorazepate, diazepam, estazolam, flurazepam, parenteral midazolam, zolpidem. ***No dosing recommendations:*** oral contraceptives - alternative contraceptive measures required. **Refer to SmPC for full details of interactions. LEGAL CATEGORY:** POM. **PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S) & BASIC NHS COSTS:**

PRESENTATIONS	PACK SIZES	MARKETING AUTHORISATION NUMBER(S)	BASIC NHS COSTS
Bottle	30 tablets	EU/1/17/1225/001	£ 672.97

MARKETING AUTHORISATION HOLDER: Janssen Cilag International NV,Turnhoutseweg 30, B 2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM:** Janssen-Cilag Limited, 50-100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG UK. Prescribing information last revised: September 2017.

Adverse events should be reported. ▼ This medicinal product is subject to additional monitoring and it is therefore important to report any suspected adverse events related to this medicinal product. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Janssen-Cilag Limited on 01494 567447 or at dsafety@its.jnj.com.

* Viral Suppression defined as VL < 50 copies/mL.
** Treatment-experienced patients were switched from bPI and F/TDF to D/C/F/TAF.[1]
† Treatment-naive patients were randomised 1:1 to receive either D/C/F/TAF plus D/C and F/TDF placebo or D/C and F/TDF plus D/C/F/TAF placebo.[2]
†† One patient developed M184I/V (D/C/F/TAF arm).[2]

PI=Protease Inhibitor; TAF=tenofovir alafenamide fumarate; TDF=tenofovir disoproxil fumarate; ARV=antiretroviral; F/TAF=emtricitabine/tenofovir alafenamide fumarate; STR=single tablet regimen; eGFR=estimated glomerular filtration rate; D/C/F/TAF=darunavir/cobicistat/emtricitabine/tenofovir alafenamide; D/C=darunavir/cobicistat; F/TDF=emtricitabine/tenofovir disoproxil fumarate.

References:

1. Orkin C et al. Lancet HIV, 2018; 5 (1): e23-e34. doi: 10.1016/S2352-3018(17)30179-0. [Epub ahead of print]
2. Orkin C et al. Oral Presentation. Presented at 16th EACS Conference on 27 October 2017; Milan, Italy.
3. Symtuza® Summary of Product Characteristics. Available from: https://www.medicines.org.uk/emc/medicine/34148. Last accessed: October 2017.

PHGB/SYM/0118/0012a. Date of Preparation: January 2018.