The Royal Liverpool and Broadgreen University Hospitals NHS Trust

# Post exposure HIV prophylaxis following sexual exposure: A retrospective audit in a UK HIV Unit

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## Background

❖Post exposure Prophylaxis following Sexual Exposure (PEPSE) is now widely available and is given in accordance with the British Association for Sexual Health and HIV (BASHH) guidance[1].

❖Data from our Genitourinary Medicine (GUM) service suggested the need to improve the quality of PEP/PEPSE provision in order to achieve auditable outcomes.

## Aim

**The aim was to audit PEP/PEPSE prescribing against BASHH auditable outcome measures and to investigate whether a dedicated PEP clinic has improved adherence and follow up of PEP/PEPSE patients.**

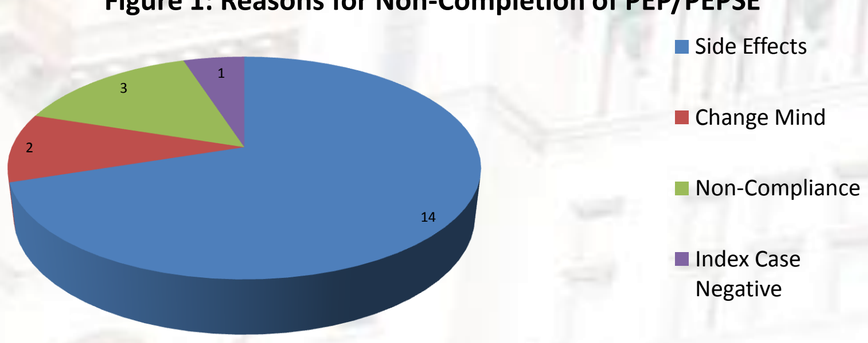
## Methods

A retrospective case note review of 100 patients in a selected time frame was reviewed. Fifty patients were selected prior to the introduction of the PEP clinic and another fifty thereafter, between 10th July 2010 and 28th February 2011. Data was recorded on Microsoft Excel.

## Results

**Auditable outcome results:** Of the 100 patients audited, 99% of PEP/PEPSE were prescribed within 72hrs of exposure and all high risk needle stick injuries were started within 24 hrs. 96% of patients had baseline HIV tests prior to starting PEP. Overall, 98% of PEP prescriptions were given in accordance with BASHH recommended indications.

**Figure 1: Reasons for Non-Completion of PEP/PEPSE**




• **Completion Rate of PEP/PEPSE results:** 59 (target 75%) patients completed their PEP course with 21 being lost to follow up, 20 did not complete treatment. Of the 59 completing their PEP, 45 attended the dedicated PEP clinic. Reported reasons for poor completion rates are shown in Fig 1.

56% (target 60%)of patients returned for an HIV test post PEP at 3 months but some testing was done at inappropriate times. Of the 56 patients tested none were positive and 39 of those were seen in the dedicated PEP clinic.

• **Pre-PEP Clinic results**: Overall, there was poor adherence and completion of PEP/PEPSE. (Table 1). Inaccurate documentation was seen in 10 patients. In half of those patients no Anti-retroviral Therapy (ART) history or hepatitis status in confirmed index cases were recorded. Whilst the offer of STI screening was done well, there was significant variation in screening times and most patients were screen too early. Four patients were not offered follow-up appointments and one of those patients double dosed Truvada for a period of two weeks.

| | Pre-PEP Clinic | PEP Clinic |
|---|---|---|
| Adherence and Completion of PEP | 14/50 (28%) | 45/50 (90%) |
| HIV Test Post PEP 3/12 | 17/50 (34%) | 39/50 (78%) |
| Completion of Hep B Vaccination | 10/50 (20%) | 25/50 (50%) |
| STI Screen 2/52 | 20/50 (40%) | 30/50 (60%) |

•**PEP Clinic results:** Following the introduction of a dedicated PEP clinic there was improved adherence and completion of PEP/PEPSE. (Table 1). Patients were followed up and screened at the appropriate times.

## • Conclusion:

Overall, there was good performance and PEP/PEPSE was prescribed according to the guidelines. The use of a dedicated PEP clinic has improved PEP/PEPSE prescribing, adherence and completion rates. There were twice as many patients who did not complete their PEP before the inception of the PEP clinic. It will be re-audited to determine how practice and prescribing habits have changed following the publication of new UK PEPSE guidelines.

1. British Association for Sexual Health and HIV (BASHH) PEPSE Guidance 2006. www.bashh.org

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