

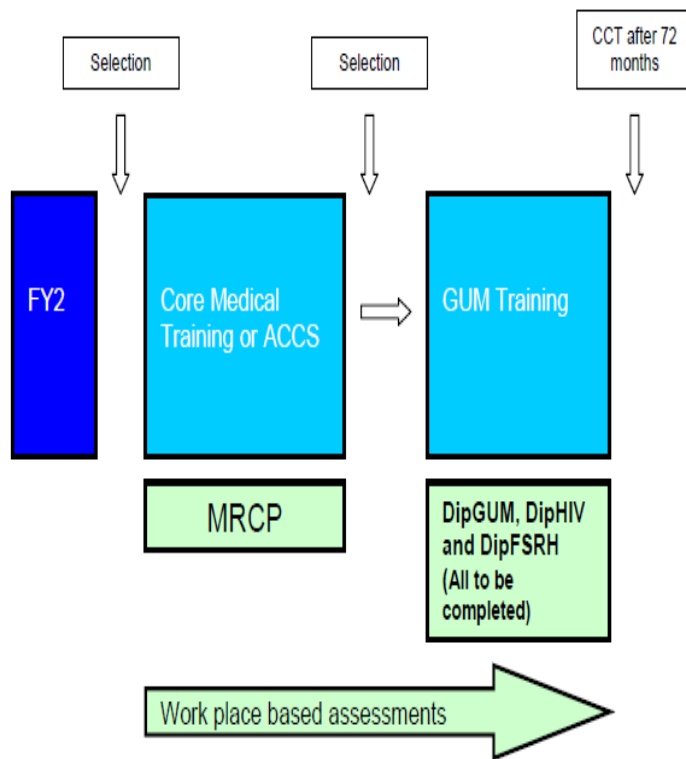
# How should we train HIV specialists from ~~2016~~ 2018?

David Asboe

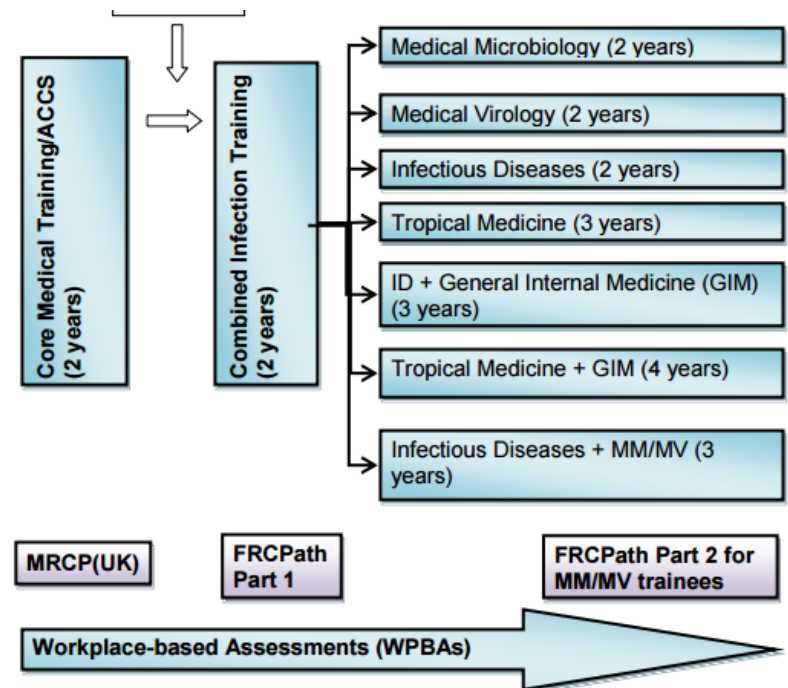
Chelsea and Westminster hospital

# Current training

## Genitourinary Medicine 2010



## Infectious diseases 2014



# GUM: HIV curriculum

## SYLLABUS

- 38 learning objectives plus 6 management/PH
- 18/38 HIV

## PROGRAMME

- OP: 1 clinic throughout training
- 1 specialist clinic
- 3 months in-patient attachment; >10 in-patients per month

## ASSESSMENT

- Workplace-based assessment
- Dip HIV Med

# HIV curriculum

## ST3 and ST4

- HIV testing
- PEP
- HIV clinic; newly diagnosed, monitoring asymptomatic, instituting and monitoring first line treatment

## ST5 and ST6

- Assessing treatment failure
- Supervised experience of ART failure, new classes
- Management of treatment related toxicity

# How is HIV Medicine changing?

## Proportion of late presenters

Number with a CD4 count	6,365	5,906	5,936	5,939	5,637	5,436	5,377	5,277	4,995	4,877
Number with a CD4 count <350	3,596	3,307	3,124	3,230	2,920	2,697	2,609	2,442	2,068	1,975
Proportion with a CD4 count <350	56%	56%	53%	54%	52%	50%	49%	46%	41%	40%

# How is HIV Medicine changing?

## Numbers with advanced immunosuppression

Total		2010	2011	2012	2013	2014
CD4 count/mm <sup>3</sup>	<350	14,617	15,065	13,668	12,978	12,621
	350-499	17,823	18,822	18,210	17,594	16,774
	>499	33,641	38,093	41,605	46,166	49,324
	Not reported	3,186	1,636	4,096	4,457	6,770
Sub total		69,267	73,616	77,579	81,195	85,489

# How is HIV Medicine changing?

## Proportion with VL BLD

Number with a Viral load	54,796	60,331	63,912	67,622	63,028
Number with a Viral load<200	50,422	55,731	59,762	63,166	59,625
Proportion with a Viral Load<200	92%	92%	94%	93%	95%

# Trends in causes of death in PLWH, 1999-2011 (DAD)

Smith *et al* Lancet 2014;384, 241-8

## Relative death rates 2009-11 vs 1999-2000

- All cause 0.72 (0.61-0.83)
- AIDS related 0.92 (0.70-1.22)
- Liver disease 0.48 (0.32-0.74)
- CVD 0.33 (0.20-0.53)

## Proportion of deaths

- AIDS related 34% vs 22% (1999-2000)
- Liver related 16% vs 10%
- Non-AIDS cancers 9% vs 23%



# **LONDON MORTALITY REVIEW OF PATIENTS WITH HIV, 2014**

S. Dhoot, S. Croxford, R. Harding, V.  
Delpech, J. Peck, S. Lucas and A. Sullivan  
on behalf of the London Mortality Study  
Group

# Causes of Death, n=189

## CANCER

AIDS related 25 (13%)

Non AIDS related 32 (17%)

Respiratory (Non AIDS / HIV) 19 (10%)

Liver (Non AIDS / HIV) 13 (7%)

Substance Misuse 12 (6%)

CVA 11(6%)

OI 10 (6%)

Sepsis 10 (5%)

Suicide 6 (3%)

CVD 5 (3%)

## OTHER

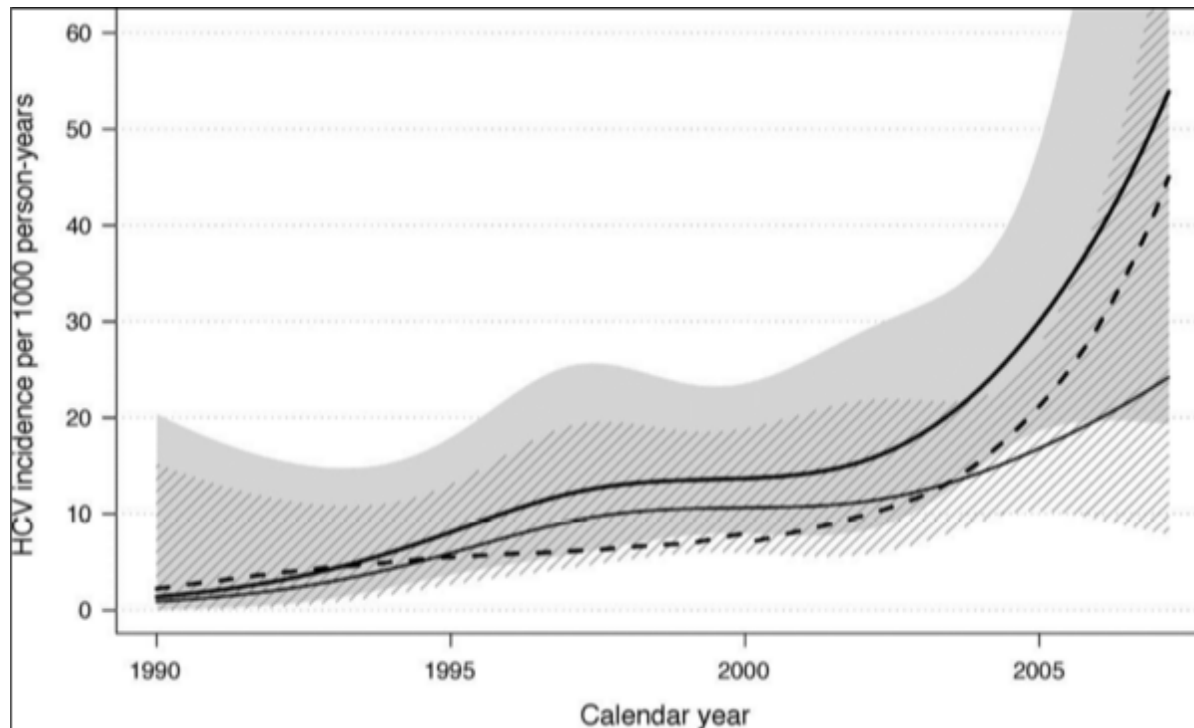
AIDS / HIV related 18 (10%)

Non-AIDS related 17 (9%)

Not Known 11(6%)

# The hepatitis C epidemic among HIV positive MSM; 1990-2007

van der Helm *et al* AIDS 2011;26' 1083-1091



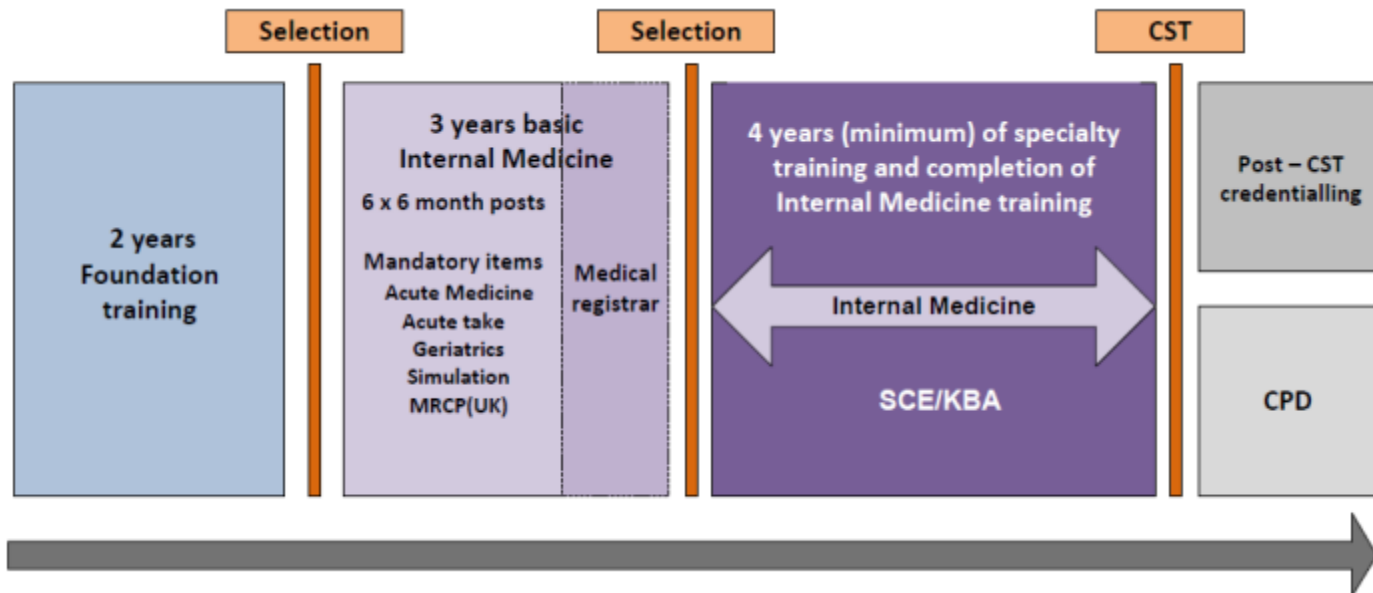
# JRCPTB – A Flexible curriculum for internal medicine

Post grad training of all doctors should be

- more patient focussed
- more general (especially in early years)
- more flexible
- allow further training by credentialling

Model for physician training

- 7 year post foundation level training leading to CST in 1. Internal Medicine and 2. specialty
- 3 years basic internal medicine, acute medical take, MRCP
- competitive entry into specialty training for 4 years
- additional 1 year internal medicine integrated into specialty training
- simplified assessment of a smaller numbers of “competencies in practice”



# Plans

HIV syllabus currently undergoing minor review

HIV curriculum for major review over next 6-12 months

- Syllabus revision, dovetailing with internal medicine
- Review of in-patient training
- Development of competencies in practice
- Review of assessments including Dip GUM/ Dip HIV
- Options for credentialling