

# Routine opt-out HIV testing in Gynaecological Oncology pre-admission clinic

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## Background

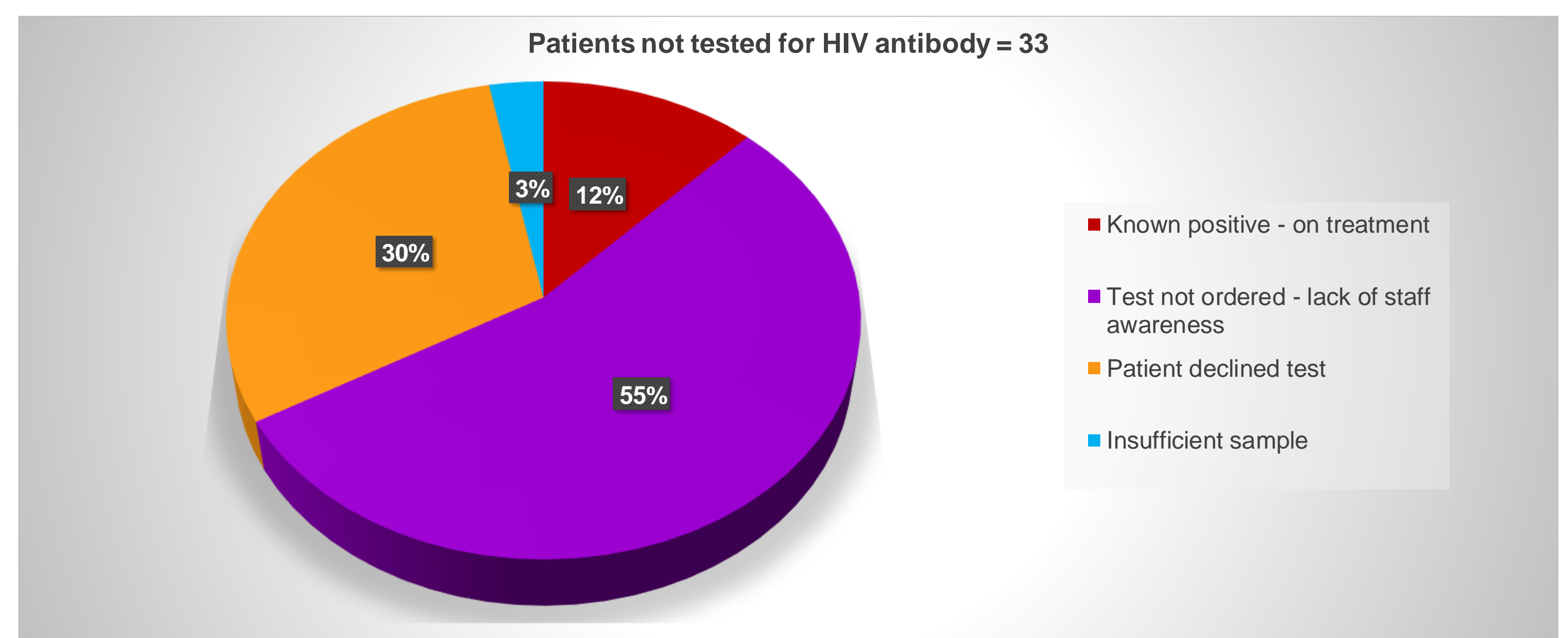
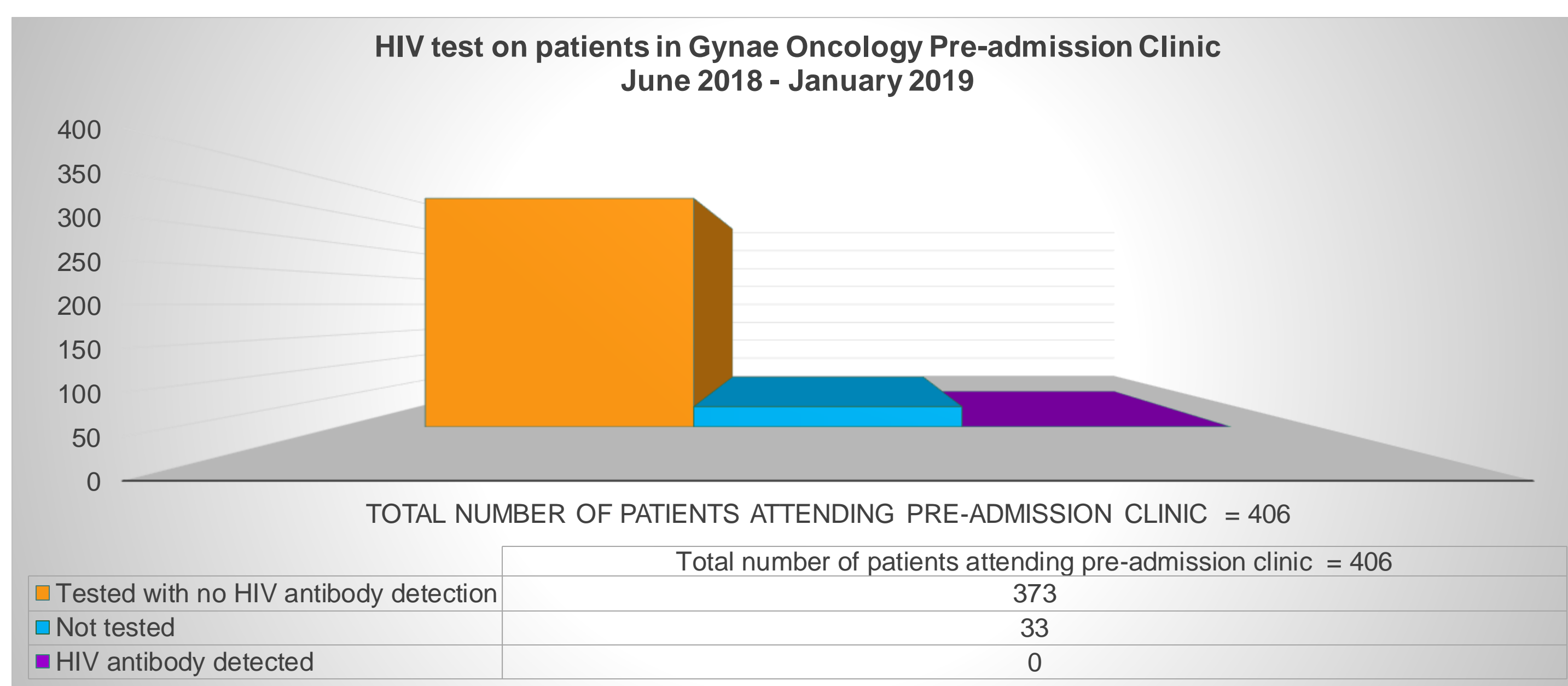
The NICE guideline 2017 recommends HIV testing be offered to all adults admitted to hospital in areas of high (>2/1000 population) and extremely high (>5/1000 population) prevalence. Tower Hamlets has a prevalence of 6.61 per 100,000. There is a 5-fold increase in the incidence of cervical cancer in women who are HIV positive and this is AIDS defining. HIV treatment can interact with chemotherapy drugs for other gynaecological cancers. Early detection is the most important prognostic factor in improving HIV outcomes and will ensure cancer patients receive optimal treatment. In June 2018, a pilot was launched for opt out HIV testing of all patients attending the gynaecological oncology pre-admission clinic. A detailed protocol was written with input from the genitourinary medicine team. The preadmission leaflet was amended to include HIV as a routine blood test and verbal consent was taken.

## Method

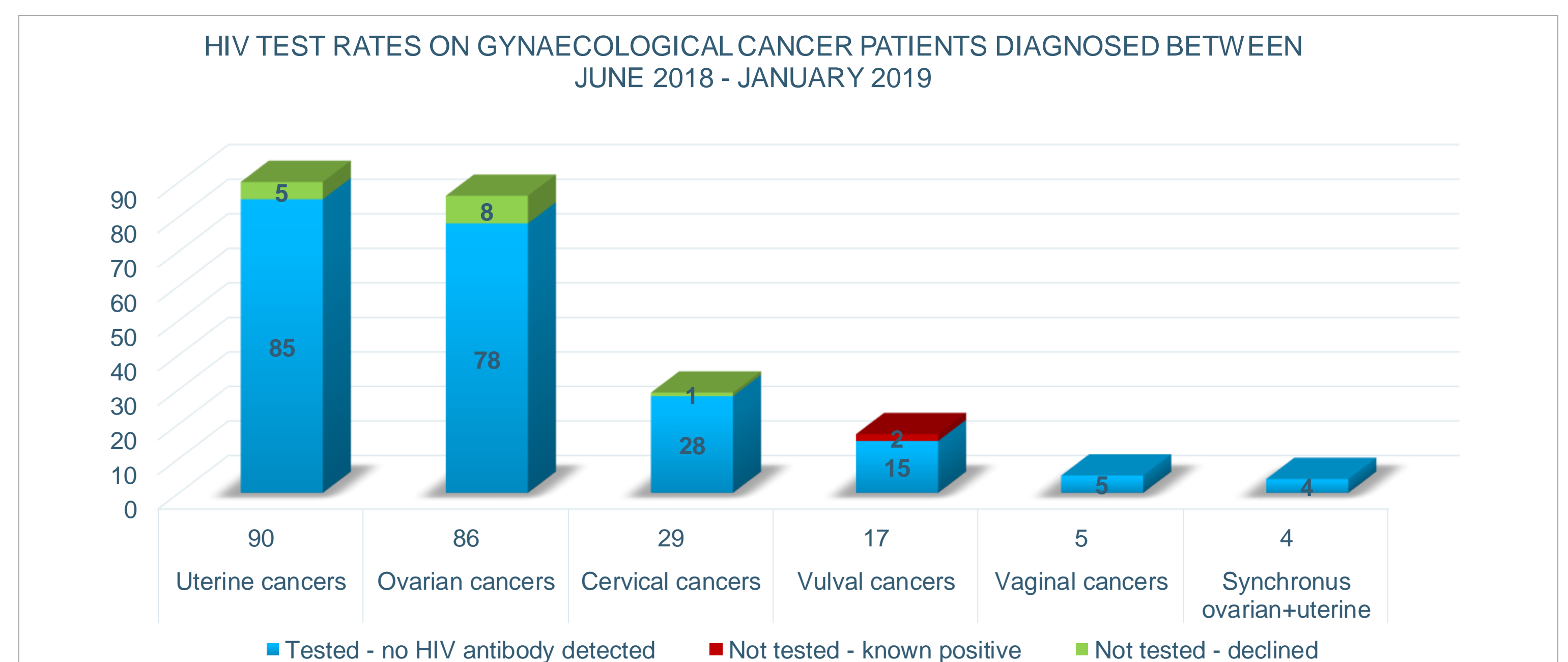
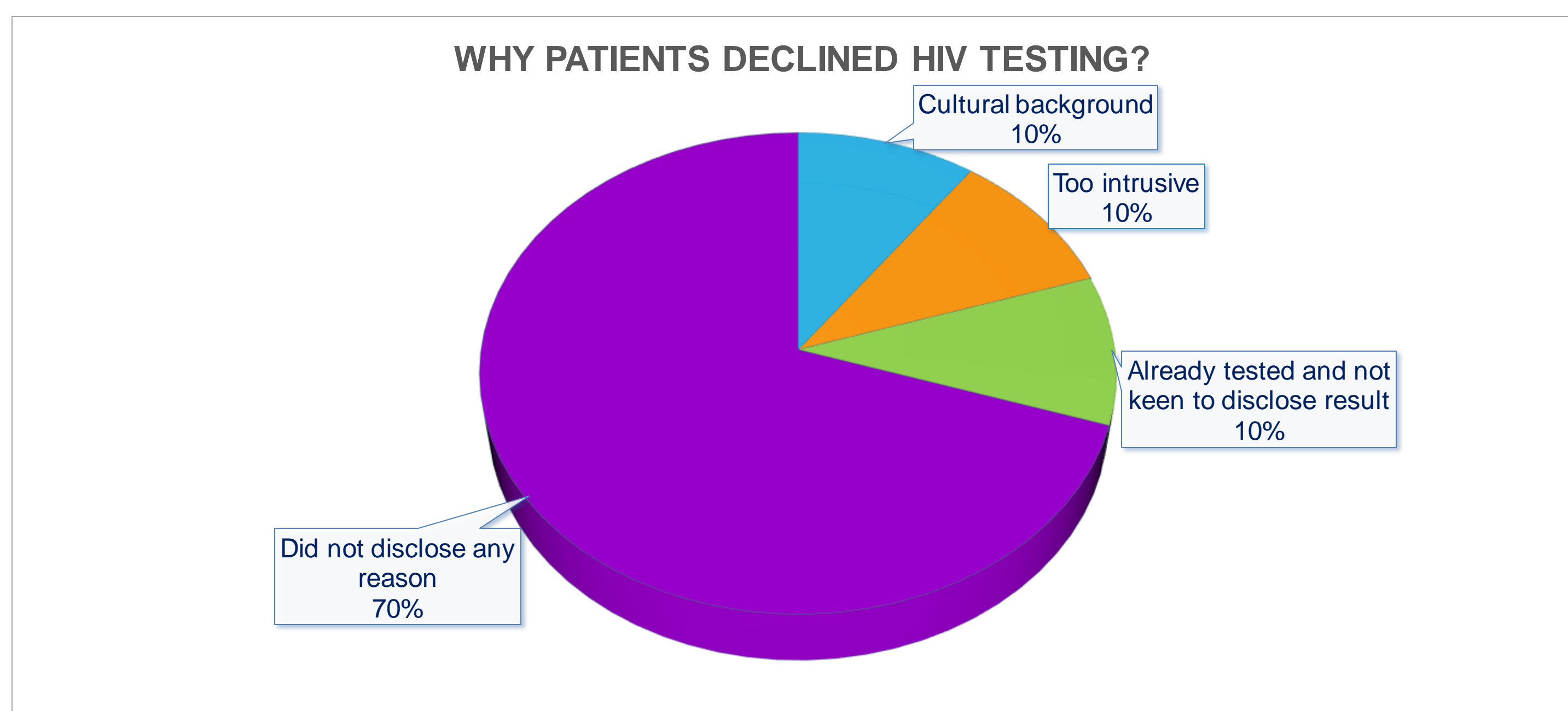
We prospectively recruited all patients attending pre-admission clinic from June 2018 to January 2019. Data were collected on demographics, site of cancer, primary diagnosis, treatment modality, HIV antibody status and reasons for declining if declined.

## Results

406 patients attended preadmission clinic. 373/406 (91.9%) were tested for HIV antibody, all of whom were negative. 33 of these 406 patients (8.1%) did not have an HIV test. In 18 patients, the HIV test was not requested due to lack of staff awareness of the pilot. 1 patient was not tested as she was difficult to bleed, and sample was insufficient. 4 patients were known to be HIV positive on anti-retroviral therapy and were not tested. 10 patients declined HIV screening, 1 patient declined in view of her cultural background, 1 thought the test was too intrusive, 1 patient had HIV test done before and was not keen to disclose result or repeat the test. 7 did not disclose the reason for declining.



242/406 (59.6%) subsequently were diagnosed with cancer. 29 women had cervical cancer who all tested negative for HIV. 17 had vulvar cancer, 15 tested negative and 2 were already known to be positive. 86 women had ovarian cancer, 90 endometrial, 5 vaginal, 4 synchronous ovarian and endometrial, 5 cancers were of another primary site and 6 breast cancer, all of whom were HIV negative. The other 2 patients known to be HIV positive had benign disease.



1 patient had an equivocal result on her initial HIV test. As the result was checked in her presence it was inadvertently disclosed, which was stressful for the patient and staff. The results were then discussed and explained to patient by one of our consultants and a member of the genitourinary medicine team. A confirmatory test was negative, indicating the initial test was a false positive.

## Conclusion

From the data collected between June 2018 and January 2019, there were no new diagnoses of HIV. The opt out approach has been acceptable to the majority of our patients and staff found it easy to integrate it into the preassessment clinic. Although at the beginning of the pilot a teaching session was held by genitourinary medicine consultant for the staff on how to approach patients about HIV testing and protocol in case of positive or equivocal results, we have learned that additional staff training is required for good clinical practice and breaking bad news. We will institute this in the near future.

