Sheffield Infection Group

A national survey of HIV testing practices within Intensive Care Units: a need to standardise patient care?

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Background

The first cases of AIDS were reported more than 30 years ago. Due to the increased life expectancy of HIV positive individuals, an influx of people living with HIV into the UK and ongoing local transmission, the prevalence of HIV continues to rise nationally.

By the end of 2010, 91,500 people in the UK were estimated to be HIV positive with 24% of these remaining undiagnosed. In the same year 6660 new diagnoses of HIV were made with 50% of these diagnoses being made late (CD4 count <350 cells/mm^3)[1]. National efforts to improve testing in myriad healthcare settings have coincided with a fall in the proportion of infected but undiagnosed individuals.

The UK National Guidelines for HIV Testing 2008[2] make no specific mention of Intensive Care. There are no national speciality specific guidelines to influence HIV testing in the unique environment and patient population of Intensive Care Units (ICUs). It is unknown how decision making in ICU is guided and what current HIV testing practice is in UK ICUs. Multiple barriers to testing in the acute hospital setting and in ICUs have previously been identified[3, 4].

Aim

The purpose of this survey was to determine current HIV testing practices and attitudes to testing in English Intensive Care Units.

Methods

A national enquiry examining HIV testing in ICUs was developed in collaboration with the Intensive Care Society (ICS). 120 ICUs were contacted by email and asked to complete an online, pre-piloted questionnaire at a dedicated website. Data was collected from 1st August to 31st October 2011.

Results

A 44% (53/120) response rate was achieved. Nine percent of ICUs (5/53) reported having written guidelines for HIV testing. Four incorporated the UK National Guidelines for HIV Testing. One based testing upon specialist advice only.

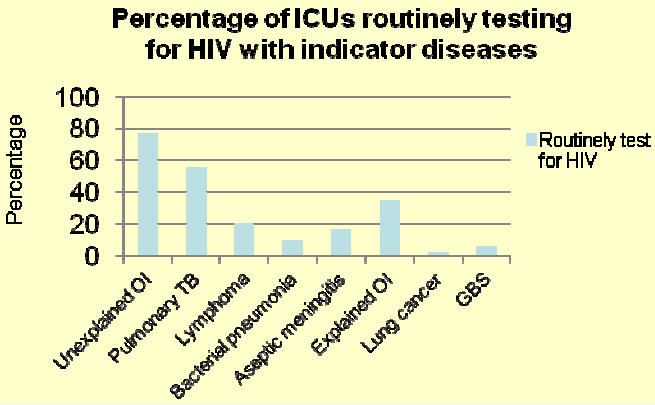
Ten units without written guidelines had discussed introducing them; with three intending to do so within the next 12 months. Of the centres without written guidelines, only 7/48 (15%) reported using the UK National Guidelines to guide testing. A further 4/48 (8%) stated they only tested on specialist advice.

The 48 ICUs without written guidelines were given a list of 8 indicator diseases and asked to state for which their units routinely tested for HIV. Eight gave no response.

Unexplained opportunistic infection (OI)	Aseptic meningitis
Pulmonary tuberculosis	Explained OI
Lymphoma	Lung cancer
Bacterial pneumonia	Guillain barre syndrome

Table 1. List of HIV indicator diseases for which ICUs were asked if they routinely tested for HIV.

No ICU routinely performed HIV testing for all eight indicator illnesses. Three declared that they would not routinely test for HIV for any of the illnesses. Unexplained opportunistic infection most frequently resulted in an HIV test with 37/48 centres testing (77%), although 11 centres did not routinely HIV test patients in this category. Only half (27/48; 56%) routinely tested in the presence of pulmonary TB, one third (17/48; 35%) routinely tested with explained OIs and one fifth (10/48; 21%) tested in the context of lymphoma. For each of the remaining indicator illnesses (bacterial pneumonia, aseptic meningitis, lung cancer and Guillain barre syndrome (GBS)) less than one in five ICUs routinely tested for HIV.



Of the 7 units without formal written guidelines who were using UK National Guidelines as a basis for HIV testing, less than half reported a more than 25% testing compliance.

Qualitative data revealed misinformed beliefs regarding HIV testing practices; perception of those 'at risk' of HIV infection and legislation for testing patients lacking mental capacity to consent:

"Very few patients in our catchment area have undiagnosed HIV. In 10 years as an ICU consultant we have not made one new diagnosis" (from ICU which does not routinely test patients with any of the above indicator illnesses).

"Microbiology will not process any tests where the patient is not competent to consent; they say these are guidelines from the Royal College of Pathologists".

"[resistance to introducing guidelines for HIV testing is] probably for reasons that are misplaced and anachronistic".

Many respondents were in favour of normalising, de-stigmatising and expanding HIV testing and called for clarification of GMC guidance in relation to testing patients lacking capacity for HIV.

Conclusions

Diverse HIV testing practices were observed across Intensive Care Units. The majority (91%) did not possess written guidelines for HIV testing. Some had discussed the need to introduce formal guidelines but only a minority had taken decisive action. Poor compliance with National Guidelines for HIV Testing was widespread.

This survey indicates a need to raise the profile of HIV testing nationally in Intensive Care. A consensus within the ICU community to standardise and increase appropriate testing will improve patient care.

References

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