Oesophageal candidiasis as an HIV indicator: are we offering HIV testing routinely?

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Introduction

Oesophageal candidiasis is a recognised HIV indicator condition and both national and European guidance recommend HIV testing routinely in cases of oesophageal candidiasis identified at oesophagoduodenoscopy (OGD) (1-3). Local HIV prevalence in Somerset is low (0.82 cases per 1,000 individuals aged 15-59) with a high proportion of late diagnoses (40.0%). We set out to establish whether HIV testing was offered in our centre and to identify potential barriers to HIV testing in cases of oesophageal candidiasis.

Method

We conducted a retrospective audit of all individuals diagnosed with oesophageal candidiasis at OGD between January 1st 2016 to January 1st 2017 using our local electronic endoscopy result database. We then conducted a search using our electronic pathology results system to identify whether HIV testing had been undertaken.

We subsequently conducted an electronic structured survey of endoscopists to identify any potential barriers to HIV testing and identify their views on which individuals should be offered testing and which clinician was best placed to arrange this.

Results

A total of 79 patients with a diagnosis of oesophageal candidiasis at OGD were identified during the audit period. The median age of this population was 69yrs. Of these individuals 5 (6.3%) had undergone HIV testing within a month before or after their OGD and 12 (15.2%) had a previous HIV result available on our local electronic pathology results system (Figure 1). There were no positive results.

![Figure 1 - Proportion of individuals undergoing HIV testing following a diagnosis of oesophageal candidiasis.]

“Since I’ve never initiated HIV testing; we only generally see oesophageal candidiasis in the frail elderly.”

Surgeon Endoscopist

At the time of the audit there were 17 upper GI endoscopists performing routine OGD in our institution (Figure 2), 11 of whom responded to the survey (65%). Of the respondents only one would routinely recommend HIV testing for a new diagnosis of oesophageal candidiasis.

![Figure 2 - Breakdown of endoscopists responding to the survey by training background.]

“Recommending HIV testing in almost all patients with candida infestations (so far, not seen a single positive result...)”

Consultant Gastroenterologist

All respondents indicated they believed arranging testing was the role of the GP or referring clinician. None of the respondents indicated that low local HIV prevalence affected their decision to arrange testing.

Discussion

Local experience would suggest that we are not screening sufficient numbers of individuals for HIV who are diagnosed with oesophageal candidiasis and there are numerous reasons why this may be the case. A number of other conditions are known to be associated with oesophageal candidiasis in the absence of an HIV diagnosis including diabetes mellitus, malignancy and pulmonary disease (4). In one study 37% of individuals on inhaled corticosteroids had oesophageal candidiasis identified at OGD compared with 0.3% of healthy controls (5).

Endoscopists in our institution identified these conditions as sufficient explanation for oesophageal candidiasis at endoscopy and this may explain the high proportion of individuals (79%) who did not undergo HIV testing. Endoscopists also identified the referring clinician as best placed to interpret the results of the OGD and arrange further diagnostic tests.

Further Work

We are currently working to develop a local standard operating procedure to improve uptake of HIV testing for individuals with a new diagnosis of this HIV indicator condition. We hope to achieve this by educating endoscopists and creating a local pathway for arranging HIV testing, this will be followed by re-audit of local figures.

References