How should we train HIV specialists from 2016-2018?

David Asboe
Chelsea and Westminster hospital
Current training

Genitourinary Medicine 2010

- FY2
  - Core Medical Training or ACCS
    - Selection
    - GUM Training
      - CCT after 72 months
      - DipGUM, DipHIV, and DipFSRH (All to be completed)
      - MRCP
    - Work place based assessments

Infectious diseases 2014

- Core Medical Training/ACCS (2 years)
- Combined Infection Training (2 years)
- Medical Microbiology (2 years)
- Medical Virology (2 years)
- Infectious Diseases (2 years)
- Tropical Medicine (3 years)
- ID + General Internal Medicine (GIM) (3 years)
- Tropical Medicine + GIM (4 years)
- Infectious Diseases + MM/MV (3 years)
- MRCP(UK)
- FRCPath Part 1
- FRCPath Part 2 for MM/MV trainees
- Workplace-based Assessments (WPBAs)
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

<table>
<thead>
<tr>
<th>Number with a CD4 count</th>
<th>6,365</th>
<th>5,906</th>
<th>5,936</th>
<th>5,939</th>
<th>5,637</th>
<th>5,436</th>
<th>5,377</th>
<th>5,277</th>
<th>4,995</th>
<th>4,877</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number with a CD4 count &lt;350</td>
<td>3,596</td>
<td>3,307</td>
<td>3,124</td>
<td>3,230</td>
<td>2,920</td>
<td>2,697</td>
<td>2,609</td>
<td>2,442</td>
<td>2,068</td>
<td>1,975</td>
</tr>
<tr>
<td>Proportion with a CD4 count &lt;350</td>
<td>56%</td>
<td>56%</td>
<td>53%</td>
<td>54%</td>
<td>52%</td>
<td>50%</td>
<td>49%</td>
<td>46%</td>
<td>41%</td>
<td>40%</td>
</tr>
</tbody>
</table>
How is HIV Medicine changing?
Numbers with advanced immunosuppression

<table>
<thead>
<tr>
<th>CD4 count/mm³</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;350</td>
<td>14,617</td>
<td>15,065</td>
<td>13,668</td>
<td>12,978</td>
<td>12,621</td>
</tr>
<tr>
<td>350-499</td>
<td>17,823</td>
<td>18,822</td>
<td>18,210</td>
<td>17,594</td>
<td>16,774</td>
</tr>
<tr>
<td>&gt;499</td>
<td>33,641</td>
<td>38,093</td>
<td>41,605</td>
<td>46,166</td>
<td>49,324</td>
</tr>
<tr>
<td>Not reported</td>
<td>3,186</td>
<td>1,636</td>
<td>4,096</td>
<td>4,457</td>
<td>6,770</td>
</tr>
<tr>
<td>Sub total</td>
<td>69,267</td>
<td>73,616</td>
<td>77,579</td>
<td>81,195</td>
<td>85,489</td>
</tr>
</tbody>
</table>
How is HIV Medicine changing?
Proportion with VL BLD

<table>
<thead>
<tr>
<th>Number with a Viral load</th>
<th>54,796</th>
<th>60,331</th>
<th>63,912</th>
<th>67,622</th>
<th>63,028</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number with a Viral load&lt;200</td>
<td>50,422</td>
<td>55,731</td>
<td>59,762</td>
<td>63,166</td>
<td>59,625</td>
</tr>
<tr>
<td>Proportion with a Viral Load&lt;200</td>
<td>92%</td>
<td>92%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Trends in causes of death in PLWH, 1999-2011 (DAD)
Smith et al Lancet 2014;384, 241-8


- 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

<table>
<thead>
<tr>
<th>Cause</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CANCER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS related</td>
<td>25</td>
<td>(13%)</td>
</tr>
<tr>
<td>Non AIDS related</td>
<td>32</td>
<td>(17%)</td>
</tr>
<tr>
<td>Respiratory (Non AIDS / HIV)</td>
<td>19</td>
<td>(10%)</td>
</tr>
<tr>
<td>Liver (Non AIDS / HIV)</td>
<td>13</td>
<td>(7%)</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>12</td>
<td>(6%)</td>
</tr>
<tr>
<td>CVA</td>
<td>11</td>
<td>(6%)</td>
</tr>
<tr>
<td>OI</td>
<td>10</td>
<td>(6%)</td>
</tr>
<tr>
<td>Sepsis</td>
<td>10</td>
<td>(5%)</td>
</tr>
<tr>
<td>Suicide</td>
<td>6</td>
<td>(3%)</td>
</tr>
<tr>
<td>CVD</td>
<td>5</td>
<td>(3%)</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS / HIV related</td>
<td>18</td>
<td>(10%)</td>
</tr>
<tr>
<td>Non-AIDS related</td>
<td>17</td>
<td>(9%)</td>
</tr>
<tr>
<td>Not Known</td>
<td>11</td>
<td>(6%)</td>
</tr>
</tbody>
</table>
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”
2 years Foundation training

3 years basic Internal Medicine
- 6 x 6 month posts
- Mandatory items: Acute Medicine, Acute take, Geriatrics, Simulation, MRCP(UK)
- Medical registrar

4 years (minimum) of specialty training and completion of Internal Medicine training

SCE/KBA

Post – CST credentialling

CPD
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