Spoken sessions

Abstract S60 Table 1 Values of CRP according to patient characteristics, stratified by HIV status

	N	Median (interquartile range)		N	Median (interquartile range)
HIV negative	447	22 (6–71)	HIV positive	86	77 (15–166) ‡
Site			Site		
CNS	11	4 (3–25) *	CNS	6	2 (1–4) ¹
Skin	10	6 (1–19)	Pulmonary	45	66 (18–166)
Lymph node	99	8 (3–28)	Lymph node	12	106 (30–142)
Pulmonary	228	32 (11–80)	Disseminated	17	103 (75–180)
Disseminated	10	48 (27–56)	Other	6	79 (22–198)
Bone and Joint	26	47 (11–69)	(includes pleural, pericardial and abdominal)		
Pleural/pericardial	24	70 (35–125)			
Sputum Smear			Sputum Smear		
Negative	87	19 (7–66) *	Negative	23	28 (9–66) ²
Positive	89	59 (19–111)	Positive	15	159 (84–248)
Unknown	20	10 (2–23)	Unknown	3	3 (1–4)
Culture result			Culture result		
Negative	97	8 (2–41) *	Negative	16	14 (1–64) ³
Positive	317	30 (9–79)	Positive	67	89 (30–191)
Unknown	12	8 (1–29)	Unknown	4	69 (12–130)

*p < 0.0001 within HIV-negative subgroup

¹p = 0.0013, ²p < 0.0001, ³p = 0.0025 within HIV-positive subgroup

‡p < 0.0001 for differences between groups.

P-values calculated using ANOVA on logged scale. Sputum smear restricted to pulmonary cases only

S61 HIGH LEVELS OF LATENT TB INFECTION, BLOOD BORNE VIRUSES, POOR TREATMENT OUTCOMES AND UNMET NEED AMONG HARD TO REACH GROUPS IN LONDON: THE TB REACH STUDY

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Background There are high rates of active tuberculosis (TB) in London's hard to reach groups (homeless people, substance misusers and prisoners). However no systematic data are available regarding the prevalence of latent TB infection (LTBI) and blood borne viruses (BBV) - HIV, Hepatitis B and C (HBV, HCV). Hard to reach groups often present late for healthcare. We undertook a TB/BBV screening programme to assess the prevalence of LTBI and co-infection with BBVs within homeless hostels, drug services and a prison in London. We also investigated management outcomes in those referred on to healthcare services.

Design/method Recruitment took place from May 2011–June 2013. Service users screened for TB on a mobile chest x-ray unit and in prison using the static digital x-ray machine were approached and, with consent, blood was drawn for IGRA (Quantiferon In-Tube) and HIV, HCV and HBV. Results were provided to participants with onward referral to healthcare services in line with current guidance. Treatment outcomes were collected via telephone follow up one year post referral for the positive cases.

Results Prison (n = 511) (Table 1)

LTBI: 65(13%) participants were IGRA positive [3(5%) co-infected with HCV]. Of these, 37(57%) were referred for preventive treatment, 16(43%) did not attend (DNA) appointments and were discharged or were lost to follow up (LFU). Of the 15 who commenced treatment, 9(60%) completed treatment.

HCV: 22 participants were positive and referred, of which 11 (50%) DNA/LFU, 11(50%) were under review and none commenced treatment.

HBV: 10 participants were positive, of which 6(60%) DNA/LFU, 4(40%) were under review and none commenced treatment.

There were no HIV positives.

Community (N=696) (Table 1)

LTBI: 116(17%) participants were IGRA positive [22(19%) co-infected with HCV]. Of the 14(12%) referred to services, 8 (57%) DNA/LFU and 3(21%) commenced treatment (2 completed).

HCV: 84 were positive and referred (8 new diagnosis), 42 (50%) DNA/LFU/declined referral, and 37(44%) under review. Five (6%) commenced treatment, one completed.

HBV: 9 participants had current infection, none started treatment; 6 were under review and 3 DNA/LFU.

HIV: 9 participants were positive and known to healthcare services.

Conclusion The prevalence of LTBI, BBVs and co-infection within the hard to reach group is high compared to the general population with fewer patients starting TB prophylaxis/HCV treatment. The high overall rates of DNA/LFU (47%) seen indicate that current approaches to onward referral and retention in care for this group appear to be poor and effective measures to improve engagement with clinical services are essential.

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S62 RISK FACTORS FOR IGRA POSITIVITY IN CONTACTS OF ACTIVE TUBERCULOSIS IN A UK HIGH-PREVALENCE SETTING

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Background Interferon-gamma release assays (IGRAs) are being used to confirm significant exposure to tuberculosis (TB) after a positive tuberculin skin test (TST). We explored the variability