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Offering HIV testing in an acute medical admissions unit in Newcastle upon Tyne

Editor – Ellis and colleagues' study provokes much thought with regard to acute admissions units and their role in asymptomatic disease diagnosis (*Clin Med* December 2011 pp 541–43). The concept of screening all patients for treatable diseases is attractive but may generate more dilemmas than solutions. The difficulty comes in choosing the diseases to screen. In the United Kingdom human immunodeficiency virus (HIV) has a prevalence of 0.15% (86,500/61,400,000).[1] This is less common than other blood born viruses, in particular hepatitis B 0.3%[2] and hepatitis C 0.4%.[3] Can we routinely test them all, and if so, is an acute admissions unit really the best place for screening?

The rate of HIV testing in the study was low. Just one in eight (478/3753) admissions were offered a test. It would have been interesting to know the characteristics and admission time of the 3275 patients not offered testing. The authors highlight that in Newcastle a large proportion of patients with a new diagnosis of HIV present late with a CD4 <200 cells/ul.[4] Furthermore, 50% of these patients had been seen by healthcare professionals with diseases suggestive of HIV. Both cases detected in the study were late presenters with AIDS-defining infections. Thus, of 3,753 admissions, no early diagnosis in asymptomatic individuals was made. The reported specificity of the Enzyngost HIV integral II test is 99.93. Had all 3,753 admissions been tested, 2 individuals would have had a false positive result (only 3 less than the 5 presumably missed cases (where the HIV prevalence is 2 per 1000)).

Population screening is a contentious issue which this study further highlights. Targeted testing (in patients at high risk of blood borne virus infection) particularly in relatively low prevalence conditions is perhaps a more favourable alternative, although a lot of patients with such diseases fail to engage in the standard models for healthcare, posing a further challenge to the screening process. It may be more appropriate to screen patients in primary care as part of a new patients registration visit permitting earlier diagnosis and treatment. This study questions the utility of HIV testing in an acute medical admissions unit.

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In response

Editor – We agree with Drs Thomas and Cross that offering HIV testing in primary care to patients with indicator diseases is more likely to reduce late diagnoses, and this recommendation is in line with the recent NICE guidance.[1,2] The main barrier is the medical practitioner, as many are unaware of situations in which HIV testing is recommended or feel uncomfortable and uneducated with respect to offering HIV testing. Blood borne viral testing for hepatitis B and C should be considered at the same time.

While the current testing guidelines constitute a significant change in clinical practice in the approach to HIV testing, it would only be successful in reducing undiagnosed infection and late diagnosis if the general clinical community and the population at risk embraced the recommendation and HIV testing is demystified.

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