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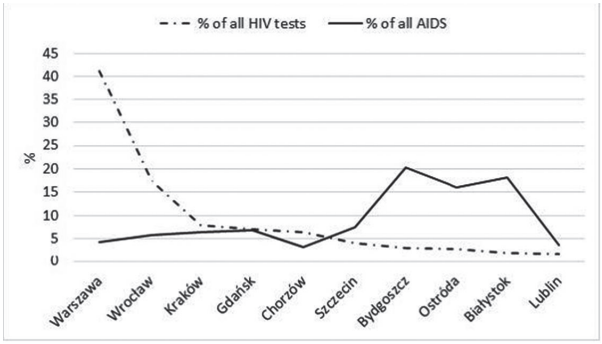
Background: Data on late presentation (LP) in Poland are not available from surveillance authorities, while to date it is the most effective measure of HIV testing access and linkage to care. To address this gap clinical centres initiated TAK Polska project to assess the prevalence and characteristics of AIDS and LP in the country.
Methods: Clinical and demographic data were collected retrospectively on predefined questionnaires for all patients newly registered in 13 HIV centres in 2016 and 2017. Data were cleaned and queried centrally. LP was defined as AIDS and/or CD4 count<350 cells/mm3 at first visit. Information on number of HIV tests performed in 2016 in voluntary counselling and testing centres (VCTs) in the region represented by each clinical centre were acquired from national VCTs system. In statistical analyses logistic regression models were used to identify factors associated with AIDS and LP.
Results: Data on 1751 patients were received (89.6% men, 64% infected through MSM contacts). The median age was 33.1 (IQR: 27.5–39.8) years, CD4 count 383 (210–552) cells/mm3. Information about AIDS at baseline was available for 1535 (87.7%) of patients: 693 (45.1%) patients were LP and 184 (11.7%) presented with AIDS. The prevalence of AIDS was highest in cities from regions with lowest number of HIV tests in VCTs (Figure).



The relation between HIV test coverage and AIDS at diagnosis in Poland stratified by cities

The most common AIDS conditions: pneumocystis pneumonia (25.2%), candidiasis (22.4%), tuberculosis (14.7%) and wasting syndrome (14.0%). The odds of AIDS/LP were higher for each 10 years older (aOR 1.65[1.41–1.92] / 1.15 [0.7–1.74]), persons infected through heterosexual contacts (2.07 [1.31–3.22] / 2.18 [1.00–4.94]) and injecting drug use (4.11 [1.29–7.88] / 3.13 [1.29–7.88]).
Conclusions: LP/AIDS at first clinical visit is still common in Poland with large variation between the centres. This indicates suboptimal testing for HIV in certain regions of the country and for some groups, especially injecting drug users.

PE6/11

Loss to follow-up and re-linkage to care in a single cohort study: who do we re-link to care?

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Purpose: Describe the HIV-infected patients lost to follow-up (LTFU) at our Centre and identify variables that might predict a subsequent re-linkage to care (RLTC).
Method: We conducted a single center, retrospective study including patients followed at the Infectious Diseases Clinic of San Martino Policlinic Hospital, Genoa. LTFU was defined as missing appointments for both visits and exams for≥12 months. All patients LTFU during the year 2015, who were already in care at the beginning of the previous year, were included. All RLTC up to December 2018 were registered. Data were retrieved through medical records and the electronic MedInfo database. The possible association of different variables with RLTC was assessed through univariable logistic regression model.
Results: Sixty-three patients were enrolled, of whom 32 (50.8%) re-entered care. Median time between LTFU and RLTC was 1 year (range 1–3 years). Median viral load at RLTC was 46.5 copies/mL (IQR 0–1500 copies/mL). Seventeen patients (53.1%) had undetectable viral load (HIV RNA<50 copies/mL) at RLTC. Other characteristics of the two populations are illustrated in table 1. At univariable logistic regression, only age showed a statistically significant association with RLTC (OR 0.9; 95% CI 0.9–1.0; p=0.033). No multivariable analysis was performed due to the small sample size.
Conclusion: To maintain linkage to care is crucial in the cascade of care of HIV-infected patients.
Half of the patients we LTFU in 2015 re-entered care after a median time of 1 year; half of them had an undetectable viral load upon re-linkage, testifying that they carried on antiretroviral treatment despite the apparent LTFU. Younger age was the only factor we found could predict the re-entrance in care.
Limitations to the interpretability of our data stem from the small sample size and the retrospective design of the study, with a consistent amount of missing data.

Table 1. Characteristics of LTFU and RLTC populations with unadjusted odds ratio and corresponding 95% confidence intervals.

	LTFU, n=63 (100%)	RLTC, n=32 (50.8%)	Unadjusted OR (95% CI)	P-value
Sex	Male 41 (65.0) Female 22 (35.0)	Male 18 (56.3) Female 14 (43.7)	0.5 (0.2–1.3) Reference	0.139
Median Age	53 years (IQR 45–60)	49 years (range 43–58)	0.9 (0.9–1.0)	0.033
Origin	European 55 (87.3) Other 8 (12.7)	European 29 (90.6) Other 3 (9.4)	Reference 0.5 (0.1–2.5)	0.426
Type of transmission	Sexual 29 (59.2) Other 20 (40.8) Missing 14	Sexual 15 (55.6) Other 12 (44.4) Missing 5	Reference 1.4 (0.4–4.4)	0.568
CDC stage	A 26 (45.6) B 16 (28.1) C 15 (26.3) Missing 6	A 17 (56.7) B 6 (20.0) C 7 (23.3) Missing 2	Reference 0.3 (0.1–1.2) 0.5 (0.1–1.7)	0.193
Psychoactive treatment	Yes 11 (21.2) No 41 (78.8) Missing 11	Yes 6 (21.4) No 22 (78.6) Missing 4	1.0 (0.3–3.9) Reference	0.958
Heroin replacement therapy	Yes 7 (13.2) No 46 (86.8) Missing 10	Yes 4 (14.3) No 24 (85.7) Missing 4	1.2 (0.2–6.1) Reference	0.806
Median time since HIV+ diagnosis	12 years (IQR 6–22)	12 years (IQR 8–23)	1.0 (1.0–1.1)	0.565
Median nadir of CD4+	158 cell/mL (IQR 61–315)	202 cell/mL (IQR 80–378)	1.0 (1.0–1.0)	0.372

PE6/12

Expanding access to HIV tests in 13 cities in Indonesia: an interrupted time series investigating effect of HIV policy intervention using six years population data

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Purpose: To control the growing HIV epidemic in Indonesia, the Strategic Use of Antiretroviral (SUFA) was launched in 2013. Since an evaluation of SUFA's impact on the rate HIV testing and detection has not been performed, we performed a study to assess the impact on these outcomes.
Method: Monthly data were collected from persons 15 years of age or older from 13 cities. The pre-SUFA data collection period was defined as 26 Dec