

# Abstract Supplement

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Virology and  
Immunology  
Models of Care  
ARV-based  
Target Prevention  
Populations  
Community  
Initiatives  
Opportunistic Infections  
Co-morbidities  
& complications  
Treatment  
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**Abstract P212 – Table 2. Associations between risky alcohol consumption (AUDIT score  $\geq 8$ ) and other health and sexual behaviour variables among HIV-negative patients**

	Proportion of patients reporting risky alcohol consumption (n = 25/69 (36.23%))	OR (95% CI)	p value	aOR (95% CI)	p value
Depressive symptoms (PHQ-9)					
None/mild	19/60 (31.67)	1.00		1.00	
Moderate/severe	6/9 (66.67)	4.32 (0.92 to 20.27)	0.05	3.99 (0.85 to 18.63)	0.08
Drug-related problems (DUDIT)					
No	12/43 (27.91)	1.00		1.00	
Yes	10/20 (50.00)	2.58 (0.83 to 8.05)	0.09	2.29 (0.60 to 8.76)	0.22
Chemsex					
No	12/37 (32.43)	1.00		1.00	
Yes	12/31 (38.71)	1.32 (0.48 to 3.60)	0.59	0.91 (0.25 to 3.26)	0.88

patients and evaluated the effects of socio-demographic, health and sexual behaviour factors on the risky alcohol consumption using logistic regression. All analyses accounted for other variables associated with risky alcohol consumption in univariate analyses ( $\leq 0.10$ ).

**Results:** The HIV-positive and HIV-negative patients were predominantly men (92% and 94%, respectively) of white ethnicity (76% and 67%, respectively) with a median age (IQR) of 46 (39 to 53) and 40 (33 to 47), respectively. Twenty-five percent of HIV-positive and 36% of HIV-negative patients reported risky alcohol consumption. Depressive symptoms (PHQ-9 score  $\geq 10$ ), harmful drug use (DUDIT score men  $\geq 6$ ; women  $\geq 2$ ) and smoking were reported in 10% and 13%, 25% and 29% and 19% and 17% respectively among HIV-positive and HIV-negative patients. Among HIV-positive and HIV-negative patients 44% and 82% reported  $\geq 3$  sexual partners, 45% and 86% unprotected sex, 15% and 30% STD diagnoses and 23% and 45% chemsex participation respectively in three months preceding the survey. Majority (88%) of HIV-positive patients adhered well to ART (CASE score  $> 10$ ). Presence of depressive symptoms ( $p < 0.001$ ), smoking ( $p = 0.04$ ), harmful drug use ( $p < 0.001$ ), chemsex participation ( $p < 0.001$ ) and poor adherence to ART ( $p = 0.01$ ) were associated with risky alcohol consumption among HIV-positive patients in the univariate analyses, but only depressive symptoms ( $p = 0.03$ ) and harmful drug use ( $p = 0.007$ ) remained significant in multivariable analyses. Among the HIV-negative patients presence of depressive symptoms and harmful drug use had borderline associations with risky alcohol consumption ( $p = 0.05$  and  $0.09$  respectively) in univariate analyses, but in multivariable analyses these associations diminished (Table 1, 2).

**Conclusions:** Risky alcohol consumption was observed in a quarter of our HIV-positive participants and was associated with increased depressive disorders and harmful drug use. Among a sample of our HIV-negative patients these associations were not present.

## P213

### Health status and quality of life in PLWHIV: results from the ICONA cohort

A Cingolani<sup>1</sup>; J Romaine<sup>2</sup>; A Tavelli<sup>3</sup>; F Maggiolo<sup>4</sup>; E Girardi<sup>5</sup>; A Antinori<sup>6</sup>; A Cascio<sup>7</sup>; A Cattelan<sup>8</sup>; A De Luca<sup>9</sup>; M Murray<sup>10</sup>; A D'Arminio Monforte<sup>11</sup>; C Bradley<sup>12</sup>; on behalf of Icona Foundation Study Group

<sup>1</sup>Institute of Infectious Diseases, Catholic University, Roma, Italy. <sup>2</sup>Health Psychology Research Unit, University of London, London, UK. <sup>3</sup>ICONA Foundation, University of Milano, Milan, Italy. <sup>4</sup>Infectious Diseases, Azienda Ospedaliera S. Giovanni XXIII, Bergamo, Italy. <sup>5</sup>Epidemiology, National Institute for Infectious Diseases L. Spallanzani, Roma, Italy. <sup>6</sup>HIV/AIDS, National Institute for Infectious Diseases L. Spallanzani, Roma, Italy. <sup>7</sup>Infectious Diseases, AOU Policlinico P. Giaccone, Palermo, Italy. <sup>8</sup>Infectious Diseases, Azienda Ospedaliera Padova, Padova, Italy. <sup>9</sup>Infectious Diseases, University of Siena, Siena, Italy.

<sup>10</sup>ViiV Healthcare, London, UK. <sup>11</sup>Infectious Diseases, University of Milano, Milano, Italy. <sup>12</sup>Health Psychology Research Ltd, Royal Holloway University of London, London, UK.

**Background:** As HIV has become a long-term condition, it is important to evaluate the impact of therapies on patient-reported outcomes (PROs). Here we report analyses of associations between clinical/demographic variables and health status and quality of life (QoL) in PLWHIV, enrolled in ICONA.

**Materials and methods:** The HIV-Dependent QoL (HIVDQoL) and EQ-5D-3L health status tool were administered consecutively to two groups of ICONA patients: newly diagnosed, pre-treatment patients and those with  $> 6$  months of cART, from March 2017 to March 2018. The analyses focused on the HIVDQoL overview item measuring generic QoL (3 = 'excellent' to -3 = 'extremely bad') and the EQ-5D visual analogue score (EQ-VAS) measuring self-rated health (100 = 'best imaginable health state' to 0 = 'worst'). Analyses included non-parametric tests of difference and correlational analyses.

**Results:** One hundred and thirty-five patients were included (122 men; 13 women), mean age 43 (SD 12.25). One hundred and seven patients were on cART (NNSTI, N = 66; NNRTI, N = 23; PI, N = 15/r-based regimen). Mode of transmission included: MSM (N = 76), heterosexual (N = 40) and IDU (N = 10). Mean CD4+ was 655/mm<sup>3</sup> (SD 316) for those on cART and 429/mm<sup>3</sup> (SD 259) for patients' pre-treatment. Mean self-reported health (EQ-VAS) was 79 (SD 14.57) for cART-treated and 78 (SD 18.73) for those pre-treatment. Generic QoL (HIVDQoL item (1) mean was 1.21 (SD 1.19) (>'good' QoL) for cART-treated and 0.48 (SD 1.74) (midway between 'neither good nor bad' and 'good') for those pre-treatment. EQ-VAS health scores were found to differ by mode of transmission, with MSM reporting better health than IDU ( $p = 0.022$ ) and those reporting heterosexual transmission ( $p = 0.043$ ). However, there was no difference in QoL by mode of transmission. Treatment with cART was associated with better QoL than pre-treatment status ( $p = 0.049$ ), without differences in health ratings. QoL, but not health status, was significantly worse for patients with CD4 count of  $< 200$  than those with CD4 count of 200 to 499 ( $p = 0.035$ ) or CD4 count  $\geq 500$  ( $p = 0.037$ ). Correlational analyses for cART-treated patients showed age was negatively related to both QoL ( $-0.312$ ,  $p = 0.001$ ) and health ( $-0.357$ ,  $p < 0.001$ ).

**Conclusion:** Although both generic QoL and health status were worse in older (vs. younger) PLWHIV, the two outcomes showed different patterns according to clinical variables, with cART-treated patients reporting better QoL but no difference in perceived health compared with pre-treatment patients. QoL, but not perceived health, was also better in patients with CD4 counts  $> 200$ . Perceived health, but not QoL, differed with mode of HIV transmission. QoL is not simply a reflection of health status and it is important to measure both outcomes.