In 2014, there were 38,700 (95% credible interval: 37,500-41,400) people living with HIV in London, of which 10% (95% CI: 7.1-16%) were unaware of their infection.1

All causes mortality among people with HIV in London has remained relatively stable over the past decade (Figure 1).5

We present findings of the 2016 audit conducted by the London HIV Mortality Study Group. This group, established in 2013, conducts annual reviews of deaths among HIV patients to reduce avoidable mortality and improve patient care.

Figure 1. Deaths among people with HIV in London: 2006-2015

METHODS

All London trusts commissioned by NHS England to provide HIV care reported 2016 data on patients who died at their centre or who attended for routine care prior to death. Data were submitted using a modified Causes of Death in HIV (CoDe) reporting form including information on: comorbidities, antiretroviral therapy (ART), clinical markers, cause of death and end of life care.5

Clinicians were also asked to make a decision as to whether each death was expected (e.g. those receiving planned end of life care or with a terminal condition) or unexpected (e.g. late presenters admitted at diagnosis and not responsive to treatment).

Causes of death were categorised by a pathologist and two clinicians (Figure 2).

Figure 2. Categorisation of HIV patient deaths: London, 2016

DISCUSSION & CONCLUSIONS

In 2016, over three quarters (77%) of deaths were due to non-AIDS conditions and the majority of patients were on ART and virally suppressed at their last clinic visit.

However, a significant number of patients with HIV died from AIDS related illnesses, which are preventable. HIV testing must be expanded outside of traditional sexual health clinic settings to reduce late diagnosis and reach vulnerable populations.4

To further reduce avoidable mortality, there is a need for optimal management of comorbidities and improved health promotion through risk reduction, as underlying risk factors, such as smoking and substance misuse were common. Strong psycho-social support is needed for people with HIV, given the high levels of depression, particularly in the first year of diagnosis.5

The high proportion of expected deaths in hospital shows that improvements are necessary in end-of-life care planning and collaborative decision making with patients and other specialists, such as oncology and cardiology.

RESULTS

Almost half of deaths were reported as sudden (44%; 79/177) and 36% (64/178) as unexpected.

Of the 64 people who died unexpectedly:

- 54 were men and 10 were women

- Majority aged 45-64 years old (89%; 44/64)

- 48% died in hospital

- 81% (43/53) patients were reported to be on ART at death

- 79% (46/58) were reported to have an undetectable viral load at death (>200 copies/ml)

- Cause of death by whether the death was expected can be seen in Figure 5.

Among people who died unexpectedly, 18% (9/50) died of accident/suicide, 16% (8/50) died of cardiovascular disease and 14% (7/50) died of non-AIDS malignancies. In contrast, people who died unexpectedly more commonly died of liver disease (29%; 30/103) and AIDS-defining illnesses (27%; 28/103).

Overall, 60% (63/104) of expected deaths were in hospital (Figure 6).

Two thirds of expected deaths (48/72) had a prior end-of-life care discussion, though this information was only available for 57% of patients.

Figure 3. Risk factors in the year prior to death by sex: London, 2016

Figure 4. Prevalence of co-morbidities among people who died by sex: London, 2016

Figure 5. Cause of death by whether the death was expected: London, 2016

Acknowledgements

We gratefully acknowledge the continuing support of London HIV services in reporting HIV death data:

- Chelsea & Westminster NHS Foundation Trust
- King’s College NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West Healthcare NHS Trust
- North West London NHS Trust
- North West London Hospitals NHS Trust
- South East London Healthcare NHS Trust
- South East London and Medway NHS Trust
- South Thames Healthcare NHS Trust
- St George’s University Hospitals NHS Foundation Trust
- St George’s University Hospitals NHS Foundation Trust

Presented at the 23rd International AIDS Conference - Amsterdam, the Netherlands

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