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Rejoinder to: Implementation of low dead space syringes in response to an outbreak of HIV among people who inject drugs: A response to Kesten et al.

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We welcome this response and example of a successful detachable low dead space syringe (LDSS) implementation. The Glasgow example is very promising and supports our findings that detachable LDSS are likely to be acceptable “if they work as well as the original equipment” (Kesten et al. 2016). Such evidence will further encourage other needle and syringe programmes and service providers to consider introducing this equipment.

The implementation recommendations we made were not intended to be prescriptive, rather they were intended to support service providers, who are considering the implementation of LDSS within their normal operations, to “enhance the acceptability of detachable LDSS” (Kesten et al. 2016), as opposed to an outbreak scenario where a more pragmatic approach is normally required. The Glasgow experience offers insight into implementing new equipment in a very different environment, both in terms of the urgency of response and the risk requiring a harm-reduction response, e.g. HIV outbreak compared to long-term high prevalence of Hepatitis C. We believe it would be useful to explore these differences to increase our understanding of effective needle and syringe provision supply in the UK.

While recognising concerns about inadvertently encouraging the sharing of injecting equipment, we stand by our assertion that informing people who inject drugs (PWID) about the beneficial features of less wasted drug and the lower risk of transferring infections is likely to support the acceptability of detachable LDSS as it recognises their priorities in regards to the properties of injecting equipment as well as the health benefits. In our paper we also argue that encouraging appropriate syringe rinsing methods for PWID known to re-use or share equipment is required given that although Hepatitis C is undetectable after one rinse in the fixed LDSS, several rinses are required for

detachable LDSS (Binka et al. 2015). We are pleased that the Glasgow LDSS implementation will be evaluated in relation to blood-borne virus incidence and prevalence. This will make a valuable contribution to the currently limited evidence base.

Finally, we were interested in another aspect of notable difference between Bristol and Glasgow; the use of preferred equipment by PWID. In contrast to the Glasgow setting, PWID in Bristol prefer 1 ml barrels for their detachable needles over 2 ml barrels. At the time of our study, Frontier Medical Supplies offered a 1ml barrel with a displacement spike for Bristol Drugs Project to try. This was not popular with service users as it does not have a backstop. There was also a lack of adequate data on volume reduction offered by the displacement spike compared to the equipment in use so this was excluded from the study at an early stage. It is not clear from the response, how the reduction in fluid content by 70% compares to previous work (Binka et al. 2015). We agree with the responders that a barrel that is compatible with all existing needles would be ideal.

References

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