n nor risk factors for HEV. Although HEV serology was initially equivocal, IgG and IgM later became positive with detectable PCR. His ALT normalised and HEV-PCR became undetectable four weeks later.

Discussion/conclusion HEV appears to be a self-limiting-asymptomatic illness in HIV+ MSM with good CD4 counts. HEV may be sexually transmitted in populations with increasing STI rates. HEV should be considered a potential cause of elevated liver enzymes in HIV+ patients.

P35 ARE TESTICULAR MIXED GERM CELL TUMOURS ASSOCIATED WITH HEPATITIS C(HCV) IN HIV INFECTED MEN WHO HAVE SEX WITH MEN?

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10.1136/sextrans-2015-052126.79

Background/introduction HCV infection and testicular germ-cell tumours are indicator diseases for HIV-testing in BASHH-guidelines. There is little data on the association of testicular tumours in MSM with HIV.

Aim(s)/objectives We describe 2 MSM with treated HIV-Hepatitis C co-infection who were both subsequently diagnosed with mixed-germ-cell testicular tumours.

Case details Patient-1 is a 51-year-old MSM, diagnosed with HIV in 2004 on Atripla since 2010. In May 2012, routine ALT = 186 and positive HCV-RNA (genotype 1). This was treated with 48-weeks of pegylated-interferon/ribavirin. He had a sustained-viral-response (SVR). Two years later, he presented to the STI-clinic with a four month history of testicular swelling. Ultrasound showed this to be likely malignant infiltration, AFP = 2484, LDH = 426, HCG = 5.9. After orchidectomy, histology demonstrated mixed germ cell tumour. He is in clinical/radiological remission. Patient-2 is a 41-year-old MSM diagnosed with HIV in 2008 and 2012 routine ALT = 918,505 respectively and HCV-RNA was positive (genotype 2/3)(genotype 1). HCV was treated with pegylated-interferon/ribavirin both times with SVR. Anti-retrovirals (Atripla) were started in 2012. That year, he pre- presented with an E-Coli-UTI and testicular swelling. Ultrasound/orchidectomy found a mixed germ cell tumour. He is in clinical/radiological remission. Patient-2 is a 41-year-old MSM diagnosed with HIV in 2004. In 2007 he received IL-2 in a clinical trial. In both 2008 and 2012 routine ALT = 918,505 respectively and HCV-RNA was positive (genotype 2/3)(genotype 1). HCV was treated with pegylated-interferon/ribavirin both times with SVR. Anti-retrovirals (Atripla) were started in 2012. That year, he presented with an E-Coli-UTI and testicular swelling. Ultrasound/orchidectomy found a mixed germ cell tumour. He is in clinical/radiological remission.

Discussion/conclusion HIV infection and hepatitis C treatment are immunosuppressive and are potential causative factors in these HIV-MSM testicular germ-cell tumours. Early investigation of testicular swellings in men with HIV-Hepatitis C is important.

P36 AUTOIMMUNE HEPATITIS IN A PATIENT WITH HIV AND HEPATITIS B CO-INFECTION ALONG WITH LATENT TB: A THERAPEUTIC DILEMMA

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10.1136/sextrans-2015-052126.80

Background/introduction Liver disease is an important cause of morbidity and mortality in patients infected with HIV infection. Abnormal liver function tests are frequently encountered in these patients and often attributed to HAART. Autoimmune Hepatitis is a rare disease with unclear pathogenesis; several viruses have been proposed to act as triggering agents for the inflammatory process of the disease.

Discussion/conclusion HIV infection and hepatitis C treatment are indicator diseases for HIV-testing in BASHH-guidelines. There is little data on the association of testicular tumours in MSM with HIV.

Aim(s)/objectives We describe 2 MSM with treated HIV-Hepatitis C co-infection who were both subsequently diagnosed with mixed-germ-cell testicular tumours.

Case details Patient-1 is a 51-year-old MSM, diagnosed with HIV in 2004 on Atripla since 2010. In May 2012, routine ALT = 186 and positive HCV-RNA (genotype 1). This was treated with 48-weeks of pegylated-interferon/ribavirin. He had a sustained-viral-response (SVR). Two years later, he presented to the STI-clinic with a four month history of testicular swelling. Ultrasound showed this to be likely malignant infiltration, AFP = 2484, LDH = 426, HCG = 5.9. After orchidectomy, histology demonstrated mixed germ cell tumour. He is in clinical/radiological remission. Patient-2 is a 41-year-old MSM diagnosed with HIV in 2008 and 2012 routine ALT = 918,505 respectively and HCV-RNA was positive (genotype 2/3)(genotype 1). HCV was treated with pegylated-interferon/ribavirin both times with SVR. Anti-retrovirals (Atripla) were started in 2012. That year, he pre- presented with an E-Coli-UTI and testicular swelling. Ultrasound/orchidectomy found a mixed germ cell tumour. He is in clinical/radiological remission. Patient-2 is a 41-year-old MSM diagnosed with HIV in 2004. In 2007 he received IL-2 in a clinical trial. In both 2008 and 2012 routine ALT = 918,505 respectively and HCV-RNA was positive (genotype 2/3)(genotype 1). HCV was treated with pegylated-interferon/ribavirin both times with SVR. Anti-retrovirals (Atripla) were started in 2012. That year, he presented with an E-Coli-UTI and testicular swelling. Ultrasound/orchidectomy found a mixed germ cell tumour. He is in clinical/radiological remission.

Discussion/conclusion HIV infection and hepatitis C treatment are immunosuppressive and are potential causative factors in these HIV-MSM testicular germ-cell tumours. Early investigation of testicular swellings in men with HIV-Hepatitis C is important.
P37 Sexually acquired _salmonella typhi_ urinary tract infection

Sally Wielding and Gordon Scott

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