P41 STRIBILD™ (EMTRICITABINE/TENOFOVIR/ELVITEGRAVIR/COBICISTAT) AND DARUNAVIR: A NOVEL REGIMEN FOR THE PI EXPERIENCED, RITONAVIR INTOLERANT PATIENT

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Case report We present the case of a 42 yr old female, diagnosed with HIV in 1992, presenting on a failing PI and integrase inhibitor based antiretroviral (ARV) regimen. She was intolerant to ritonavir, had significant drug resistance and poor adherence, but achieved virological suppression using the novel combination of Stribild™ [elvitegravir (EVG)/cobicistat/tenofovir (TDF)/emtricitabine (FTC)] and darunavir (DRV). She had been on multiple ARV combinations since 1994, including NRTI mono-therapy. Medication intolerance, non-adherence and stopping ARVs against advice, had led to HIV drug resistance. Her regimen comprised raltegravir (RAL), DRV, RTV and TDF. Due to her intolerance to RTV, she took this sporadically. This resulted in viral rebound from <40 c/ml to 5,483 c/ml. Cumulative resistance assays demonstrated NRTI, NNRTI and protease inhibitor mutations. Her virus was X4 tropic, but remained sensitive to integrase inhibitors.

To combat this issue a novel approach using Stribild™ with DRV 1200 mg OD was started, taking into account the patient's resistance profile and RTV intolerance. Due to minimal pharmacokinetic (PK) studies of this combination, and the potential for suboptimal and/or altered PK of cobisistat, EVG and DRV, therapeutic drug monitoring was utilised. Adherence was monitored using MEMs CAP™, which showed excellent adherence. Trough drug concentrations at 23 hrs post-dose were 2692 ng/ml for DRV and 1,155 ng/ml for EVG. Subsequently, she achieved rapid virological suppression, asymptomatically.

Discussion/conclusion Issues of drug intolerance and resistance can be a therapeutic dilemma. We present the first case study using the regimen of Stribild™/DRV, utilising cobi to enhance DRV concentrations. This well tolerated salvage regimen may be an option for some individuals.

P42 THE FORENSIC SIGNIFICANCE OF STI'S

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Background/introduction Testing for STI's following sexual assault is routine. In cases were there is no other sexual activity other than the sexual assault, the assailant may be the source, and a positive result of significance in criminal investigation.

Aim(s)/objectives The potential forensic significance of STI results should be considered in each case.

Methods Discussion on information sharing of STI results is undertaken in cases referred to a sexual assault referral centre (SARC) with an absence of other sexual activity. This is documented and includes interpretation of results.

Case 1: An adolescent female, not previous sexually activity, vaginally raped, had a bacterial STI screen and serum save taken hours after the assault. Genital discomfort subsequently developed. A presumptive diagnosis of genital herpes made and tested. Herpes antibody testing was requested on samples taken; initially, when symptomatic and post symptoms.

Case 2: An elderly female, widowed several years earlier and sexually inactive since was vaginally raped. A bacterial STI screen was taken at the time initially and 14 days later.

Results Case 1 – HSV Type 2 confirmed. HSV antibodies initially absent were demonstrated in the post symptomatic sample.
Case 2 – Initial *Chlamydia trachomatis* NAAT tested negative with a positive result at 2 weeks.

Discussion/conclusion The results are supportive of the assailants as the source. The positive Chlamydia result supported the penile vaginal penetration described, allowing consideration of a rape charge rather than a lesser offence. In both cases admissions were made pre-trial avoiding victims being called to court.

P43 DON'T FORGET TO CHECK FOR STIS…. A REPORT ABOUT GONORRHOEA PROCTITIS BEING MISTAKEN FOR A FLARE-UP OF CROHN'S DISEASE

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Background/introduction STIs are not routinely tested for in hospital which means they are often missed when they are an important differential diagnosis.

Aim(s)/objectives To present a case of rectal gonorrhoea (GC) in a patient with well-controlled Crohn's disease (CD) who presented to gastroenterology before diagnosis of GC in GUM.

Methods Case report and literature review.

Case report A 37 year old man presented to gastroenterology with diarrhoea, abdominal pain, proctalgia and tenesmus. He was known to have CD which had been in remission with treatment. X-ray showed faecal impaction and he commenced laxatives. Bowels regularised but remained painful. He was discharged with topical diltiazem, lidocaine gel and Metronidazole. At follow up he reported continuing proctalgia and small amounts of rectal bleeding. Exploration under anaesthesia revealed a peri-anal fissure and a sinus which was de-roofed and treated with local anaesthetic. MRI showed an inflamed anal gland. Colonoscopy, biopsies and stool cultures were normal. He then attended sexual health as he recently found out his regular male partner had been unfaithful. Proctoscopy was painful and revealed discharge and inflamed anal mucosa. On microscopy > 10 neutrophils per high powered field were seen with a mixture of gram positive and negative organisms. Proctitis was treated with Doxycycline. Rectal GC tests were positive and this was treated. At test of cure symptoms had resolved and have not recurred since.

Discussion/conclusion Literature search reveals publications from recent years about STIs being initially misdiagnosed in hospital. This case further highlights the importance of asking routinely about partners in patients with bowel symptoms.

P44 RPR-NEGATIVE PRIMARY SYPHILIS IN MEN WHO HAVE SEX WITH MEN: A CASE SERIES

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Background/introduction Diagnosis of primary syphilis is confirmed by serological tests suggestive of the stage of the disease. In most cases specific (IgM/IgG) and non-specific (RPR)