antibodies develop in response to primary treponemal infection. Lack of development of such antibodies is known to occur amongst HIV positive patients but is unusual among HIV negative patients with no significant comorbidities.

Aim(s)/objectives To present a cluster of four cases of primary syphilis from our clinic with unexpected serological results.

Methods We describe four unusual cases of HIV-negative MSM, all of whom presented with penile lesions (three chancres and an atypical lesion). These cases were identified by clinicians between July 2014 and January 2015. Clinical and laboratory records were retrospectively interrogated. Clinical photographs will be used to illustrate these cases.

Results In all cases, patients with no history of previous syphilis returned positive results on one or more specific treponemal serological tests with persistently negative RPR. Three cases had recent negative syphilis screening at our clinic. Darkfield microscopy also failed to demonstrate T. pallidum in those with chancres. In all cases, treatment of presumed syphilis led to the resolution of the lesions.

Discussion/conclusion These cases demonstrate the ongoing difficulties with treponemal diagnostic test interpretation. There are reports in the literature that men over 35 may be more likely to return a false negative RPR result, but overall prevalence of false negative RPR in primary syphilis is uncertain. Over-reliance on serology may result in under diagnosis of syphilis even in HIV-negative MSM.

P45 RECALCITRANT *TRICHOMONAS VAGINALIS;* A CASE SERIES OF TREATMENT CHALLENGES AT TWO URBAN SITES

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Background/introduction *Trichomonas vaginalis* (TV) remains common in England, with 6475 cases reported in 2013.[1] BASHH guidelines[2] advocate first line TV treatment with metronidazole (2 g stat or 400 mg BD for five to seven days) or a single dose of tinidazole (2 g). Recalcitrant infections have been well documented and may be caused by inadequate therapy, re-infection or antibiotic resistance.[3] In the US, up to 5% of isolates of TV demonstrate a degree of resistance.[4] In the UK there remains no facility to test for TV resistance, leading to multiple 'blind' treatment approaches. We wished to evaluate the prevalence and clinical management of recalcitrant TV in our services.

Methods Clinic databases were used to identify patients with recalcitrant TV attending two sexual health services over a two year period.

Results A total of 1046 cases of TV were seen across the two services in the study period. Four female patients (0.4%) with recalcitrant TV requiring three or more treatments were identified. The patients were aged between aged 25 and 47 years. Two were black British, one white British and one white European. All four patients failed to respond to at least two five day courses of metronidazole; they required between three and eleven different courses of treatment, as per the table below:

During the courses of treatment all four patients were microscopy and culture negative at least once. However, symptoms persisted and tests were subsequently positive on at least one other occasion, despite no risk of reinfection. Three patients subsequently responded to fourteen days of tinidazole and one required acetarsol treatment. Three were eventually cured of TV, taking between 3–7 months to achieve cure and 5 and 12 clinic visits; one was lost to follow up, presumed cured.

Discussion Recalcitrant TV is rare, but for patients affected, the absence of a UK facility to detect TV resistance means that individuals who fail to respond to first line therapy undergo multiple attempts at TV treatment, recurrent clinic visits and investigations.

Abstract P45 Table 1 *Trichomonas vaginalis* case series

	Ethnicity	Age	First line treatment	Subsequent treatments	Time to clinical cure
1	White European	28	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days; TDZ 2 g OD 14 days	4 months (5 clinic visits)
2	Black British	47	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x3 (2 in community); MTZ 400 mg BD 5 day amoxicillin 500 mg TDS + clotrimazole pessary, TDZ 2 g STAT, TDZ 2 g BD 14 days	2 months-Lost to follow-up (5 clinic visits)
3	White British	29	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days × 3; Amoxicillin 500 mg TDS 7 days+clotrimazole pessary + MTZ 400 mg BD 5 days, TDZ 2 g OD for 14 days	3 months (6 clinic visits)
4	Black British	25	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x 3; Amoxicillin 500 mg BD 7 days + MTZ 400 TDS 7 days; MTZ 1 g suppositories 7 days + amoxicillin 500 mg TDS 7 days, MTZ 2 g OD 5 days; TDZ 2 g OD for 14 days; MTZ 400 mg TDS +1 g PR 7 days; TDZ 2 g BD 14 days + TDZ 500 mg BD PV x2 courses; Acetarsol 500 mg pessaries ON 14 days	6 months (12 clinic visits)

P46 THE MANAGEMENT OF ABNORMAL LFTS IN AN HIV POSITIVE PREGNANT WOMAN

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Background Acutely deranged liver function tests (LFTs) in HIV positive pregnant women present challenges in balancing pregnancy-related conditions, antiretroviral (ARVs) toxicities and prevention of mother to child transmission (MTCT). A 34 year old HIV positive lady with a history of poor engagement in care, psychosis, cognitive impairment and recent nevirapine resistance