therapy (ART). Our hypothesis is that any association between STIs and VF would be confounded by drug use.

Methods The OHTN Cohort Study follows people receiving HIV care in Ontario. STI results and viral load (VL) data were retrieved via linkage with the provincial laboratory. We restricted analyses to 2610 MSM who completed>=1 annual questionnaire in 2008–2014 and had two consecutive VL<50 within a six-month period on ART. VF was defined as a single VL>=1000 or two consecutive VLs>=200. Periods of STI exposure were set around the diagnosis dates for each STI. We modelled STI diagnosis exposures and drug use as time-varying covariates on risk of VF using Cox regression adjusting for age, region and income as confounders. Our model allowed for repeat STI exposures and repeated VF events using the marginal means/rates model.

Results There were 472 VFs with a 24 month cumulative incidence of 12.1% (95%CI 11.1, 13.1). VFs at time of a new chlamydia or gonorrhoea infection were close to nil. We did not observe an increased risk of VF at the time of a new syphilis infection (HR=1.2 95% CI 0.8, 2.0; aHR=1.1 95% CI 0.7, 1.7). Risk was higher among drug users (non-injection aHR=1.4 95% CI 1.1, 1.8; injection aHR=1.8 95% CI 1.1, 2.6). There was no significant interaction but some evidence of positive confounding between syphilis and VF by drug use.

Conclusion Regardless of drug use, we did not find an association between a new STI diagnosis and increased risk of VF among men on suppressive ART. Our data are limited by possible misclassification of STI exposures, because not all men were tested, and among those diagnosed, exact dates of acquisition were unknown.

P2.37 PRESENCE OF GENITAL *CHLAMYDIA TRACHOMATIS* SEROTYPE L2 INFECTION IN SOUTH AFRICAN WOMEN

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Introduction: *Chlamydia trachomatis* serotype-L, lymphogranuloma venereum (LGV), is a well-recognised infection among men who have sex with men in developed nations. In Africa, LGV is an uncommon but recognised cause of genital ulcer disease in men and women. The presence of genital infection in African women is unknown.

Methods In this pilot study we evaluated the presence of *C. trachomatis* serotype-L in 55 vaginal specimens that tested positive for *C. trachomatis*. These specimens were obtained in several studies over the period 2012–2016 that recruited women visiting a mobile health clinic in rural Mopani District (n=25) and in various settings in Pretoria: a tertiary obstetrics and gynaecology clinic (n=14), an antiretroviral treatment (ART) clinic (n=10) and a sexually transmitted infections (STI) clinic (n=6). Presence of serovar type-L of *C. trachomatis* was assessed using a targeted PCR assay and confirmed by whole-genome sequencing (WGS) of DNA from the clinical specimen.

Results We identified serotype-L *C. trachomatis* infection by targeted PCR in 8 cases. All of these women had presented with vaginal discharge at either the ART (n=5) or STI (n=3) clinic. Two women had co-infection with *Neisseria gonorrhoeae*, two with *Mycoplasma genitalium* and two with *Trichomonas vaginalis*. WGS of 5 specimens confirmed the presence of the L2 serovar. Also, one mixed infection of serovars L2 and E (minority) was observed.

Conclusion This pilot study demonstrates the presence of symptomatic cervical infection by *C. trachomatis* of serotype-L2 in African women. This confirms one report of (chronic) genital infection in African women from more than two decades ago. The significance of this observation is to be determined with regards to virulence, morbidity, distribution across the population and clinical management in the current context of the syndromic approach

P2.38 MICROBIOLOGICAL ANALYSIS FROM A PHASE II STUDY IN ADULTS EVALUATING SINGLE DOSES OF GEPOTIDACIN (GSK2140944) IN THE TREATMENT OF UNCOMPLICATED UROGENITAL GONORRHOEA CAUSED BY *NEISSERIA GONORRHOEAE*

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Introduction Gepotidacin (GEP), a novel triazaacenaphthylene antibacterial, inhibits bacterial DNA replication. A Phase 2 study evaluated GEP as a single oral dose (1.5 or 3g) in subjects with urogenital gonorrhoea.

Methods Pre-dose specimens were obtained for culture and susceptibility testing by agar dilution. Microbiological success (MS), was culture confirmed eradication of *N. gonorrhoeae* (GC) at test-of-cure (TOC), 3–7 days post dose, in the microbiological evaluable (ME) population which consisted of all randomised subjects with culture confirmed urogenital gonorrhoea at baseline, who received any dose of GEP and returned for TOC.

Results Against 69 GC isolates recovered from baseline urogenital specimens in the ME population, GEP minimum inhibitory concentration [MIC (μg/mL)] range was ≤0.06–1 and MIC90 was 0.5. Resistance (R) to comparators were 33%, 28%, 20%, 0%, 0% and 0% for ciprofloxacin (CIP), penicillin, tetracycline, ceftriaxone, cefixime and spectinomycin, respectively. 2 isolates had elevated azithromycin MICs (MICs=2). Overall MS was 96% (66/69) in the ME population. PK/PD analysis showed 100% (61/61) MS when the free area under the curve/MIC ratio (*f*AUC/MIC) was ≥48. MS decreased to 63% (5/8) at *f*AUC/MICs ≤24. All isolates from the 3 urogenital failures were CIP-R, had a baseline GEP MIC=1 and a pre-existing D86N mutation in ParC, a critical residue in GEP binding. 2 were treated with a 3g GEP dose (*f*AUC/MICs=24) and 1 was treated with a 1.5g GEP dose (*f*AUC/MIC=12). 5 additional isolates with D86N were MS (2 at GEP MIC=1, 3 at GEP MIC ≤0.25). Isolates from 2 failed subjects (3g GEP dose) demonstrated R emergence to GEP (MICs increased ≥32 fold) and had an additional mutation (A92T) in GyrA, also located in GEP binding pocket.

Conclusion Subjects with *f*AUC/MICs ≥48 were MS, including 3 with D86N (*f*AUC/MICs ≥96). Further study of GEP, in the treatment of gonorrhoea is warranted, including demonstration that higher exposures suppress R in key isolate subsets.

P2.39 COMPLETE REVERSAL OF AN ABERRANT TUMOUR BY KAPOSI'S SARCOMA IN A PATIENT WITH HIV USING HAART PLUS LIPOSOMAL DOXORUBICIN

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Introduction Kaposi's Sarcoma (KS) is the most common HIV related neoplasm since the outburst of the HIV epidemic in early 1980s. After the widespread use of highly active antiretroviral therapy (HAART) its incidence has declined drastically, but even today patients find themselves infected with HIV after developing KS.
Methods Case Report.
Results We report the case of a 36 years old, African-american, bisexual man who had his HIV diagnosis on october 2014 after the onset of violaceous, nodular skin lesions all over his body six months earlier. At first visit to our service he has presented with 70 skin lesions, 69 of them were violaceous and nodular, one oral mucous lesion and typical biopsy-proven gastric and sigmoid lesions. His CD4 count was 99 cels/mm3 and HIV viral load was 3412 copies/mm3 (log 3.533). His KS was classified as T1S1. The most disturbing finding, though, was an aberrant presentation of KS on his 2nd left pododactyl, affecting and disturbing the entire normal architecture of this toe, making it three times bigger than usual, displacing the fingernail, along with other nodular lesions on the dorsal face of the left feet.This lesion was very secretive, with a clear and foetid fluid. Patient had already started TDF/3TC/EFZ plus sulfametoxazol-trimetoprim 1 week earlier and we prescribed liposomal doxorubicin, 20mg/m^2 each 21 days, alongside with special dressings on this tumoral lesion thrice a week. He achieved undetectable viral load and CD4 cell count of 117 cells/mm^3 four months later. Patient received 26 chemotherapy sessions from December 2014 to April 2016, with a total dosage of 852 mg of liposomal doxorubicin and achieved a complete response, with healing of all skin, mucous and visceral lesions, including a full recovery of the 2nd pododactyl.
Conclusion A combination of HAART plus extensive chemotherapy and proper dressings was successful to completely heal an unusual aberrant tumour in a patient with disseminated KS.

P2.40 ANOGENITAL WART WITH ATYPICAL MORPHOLOGICAL FEATURES IS NOT ALWAYS AN ALARMING SIGNAL FOR THE TREATING PHYSICIAN

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Introduction The clinical morphology of anogenital warts may vary from flat, filiform, popular or verrucous to giant condyloma acuminata, and Buschke-Löwenstein tumour. Clinically atypical-looking genital warts may alarm the clinician because of their suspected malignant potential, which may cause anxiety, often leading to aggressive interventions. We conducted this study to find out whether clinically atypical-looking anogenital warts are more likely to be premalignant or malignant as compared to typical warts.
Methods Data of forty-one (37 males, 4 females) patients with anogenital warts was retrospectively analysed. After a detailed literature review and in-house discussions, criteria for anogenital warts with typical and atypical clinical morphology were defined. Clinical photographs of the anogenital warts were independently reviewed by three dermatologists, and HPV genotyping results, histological evaluation, and immunohistochemical analysis for p53 expression were evaluated.
Results Fifteen (36.6%) anogenital warts were classified as atypical by at least two out of three blinded dermatologists. The histological examination showed mitotic figures in 29/41 (70.8%), dysplasia in 14/41 (44.1%) specimens and p53 positivity in 34/41 (82.9%) of specimens. There was no significant difference in the high-risk HPV genotyping (p=0.6), frequency of dysplastic changes on histology (p=0.3) and immunohistochemistry with p53 (p=0.07) between clinically typical and atypical-appearing anogenital warts. Similarly, no significant difference was found in the frequency of dysplastic changes (p=0.3) or p53 expressions (p=0.5) based on the HPV genotypes.
Conclusion The atypical clinical morphology of anogenital warts may not be a marker of increased malignant potential. High-risk HPV genotypes do not have a statistically significant association with dysplasia or positive immunohistochemistry with p53.
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P2.41 PHARMACEUTICAL ASSISTANCE IN SYPHILIS PATIENT CARE – FROM PREVENTION TO SUCCESSFUL TREATMENT

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Introduction The expansion of Family Health in the City of Rio de Janeiro, as well as the structure that minimally requires one pharmacist per unit of Family Health Clinic, this professional has been often acting as protagonists in the success of the Treatment and follow-up. In this context, the pharmacist performance in all stages of syphilis care has become paramount for the success of the treatment, acting in all care stages.
Methods Prevention - opportunize the patient's visit to the pharmacy to identify individuals risk and eligible for actions as pharmaceutical consultation or a educational group, as responsible for the custody and control of the syphilis Rapid test allows the knowledge of the cases even before the dispensation. Surveillance and notification of public health problems - as soon as the knowledge of the diagnosis, by rapid test result or the demand for the dispensing of the medicine, is also responsible for that notification, and it is up to him to make that request to the professional who made the diagnosis