during the antibiotic treatment of various spirochete infections. It begins 2 to 8 hours after the treatment, as a flu like reaction with high fever and is sometimes associated to an aggravation of the syphilis symptoms. It usually resolves in 24 hours without treatment, but the patients usually receive antipyretic treatment. This reaction appears in 50% of primary syphilis, and up to 75% of secondary syphilis. It's very rare in latent syphilis, but can appear in 30% of neuro-syphilis. There has been only one description of a recurrent JHR, in a patient with a late latent syphilis that had 2 JHR after 2 consecutive penicillin injections. To our knowledge it has not been described in any other syphilis patient.

P2.53 BUSCHKE-LÖWENSTEIN TUMOUR IN ASSOCIATION WITH HPV TYPES 6 AND 11

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Introduction Buschke-Löwenstein tumour (BLT) is a very rare sexually-transmitted disease associated with human papillomavirus (HPV) type 6 and 11, but rare cases of oncogenic HPV types including HPV 16 and HPV 18 were also reported. BLT is located in the genital, anorectal and perianal regions. It is regarded as a type of verrucous carcinoma occurring on anogenital mucosal surfaces where it is locally invasive but displays a benign cytology. Buschke-Löwenstein tumour can be associated with a high rate of recurrence and a risk of malignant transformation to invasive SCC, especially in patients with oncogenic types of HPV.
Methods We report the case of a 59-year-old female patient who addressed our clinic for a large, exophytic, cauliflower-like tumour involving the vulva, perineum and perianal regions with 20 years duration. The first lesions had been appeared on vulva and after 3 years period they grown slowly and covered perineum and perianal area. They had cauliflower like surface, with different sizes. In some points erosions and yellowish secretion with odour are observed.
Results Histologic examination of a biopsy specimen of large tumour presented nets of well-differentiated squamous cell carcinom, as well as a marked mononuclear cell infiltrate and conspicuous koilocytosis. HPV DNA for 6, 11 types was detected with PCR.
Conclusion The patient was sent to the gynaecology surgery department for excision and remains under the supervision of the dermatology and oncology department for rapid treatment of relapses and early detection of malignant transformation.

P2.54 PENILE VERRUCOUS SQUAMOUS CELL CARCINOMA IN PATIENT WITH NON HODGKIN LYMPHOMA

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Introduction Verrucous squamous cell carcinoma (SCC), which was first described in 1948 by Ackermann, was reported in the oral cavity, anus, penis and female genitalia. This carcinoma is a low-grade SCC tumour and exhibits slow invasive growth. Regional lymph node metastases are rare and distant metastases have not been reported yet. Penile verrucous SCC carcinoma represents 5% to 16% of all penile SCC and in 33% of cases is associated with HPV type 6,11. Lack of circumcision, poor hygiene, phimosis, tight prepuce and chronic infection are other important causative factors for penile verrucous SCC carcinoma. We are reporting a case of a 70 year-old male patient who has come to our clinic with enlarging erythematous, exophytic papillary mass with foul smell located on glans penis for four- month duration. The patient is a chain-smoker and immunosuppresed due to the treatment of a non- Hodgkin lymphoma. He reported occurrence of multiple condylomata acuminata on genital area with a long lapse, which was treated with local destructive therapy and electrocoagulation. His medical history includes also ischaemic heart disease and coronary insuffiency.
Methods: Histological examination established verrucous SCC carcinoma - hyperkeratosis, parakeratosis, acanthosis with bulbous downward projections into the dermis and well-differentiated tumour cells with invasion in reticular derma with depth of 2.122 mm and desmoplastic stromal reaction. Polymerase Chain Reaction for HPV DNA detected HPV type 6.
Results and conclusion The surgical excision and amputation penis partialis in Urology surgical department showed that there was not invasion of the tumour in corpora *cavernosa* and corpus *spongiosum* and it was classificated as T1NxMx. The patient remains under the supervision of the dermatology and oncology specialists for eventual relapses.

P2.55 BOWENOID PAPULOSIS

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Introduction Bowenoid papulosis (BP) is virally induced disease caused by high risk HPV viruses, the most common type 16 and rarely type 18, 32, 39, 42, 48,53, 58. Smoking, early sexual initiation, promiscuity, risk sexualbehavior, uncircumcised sexual partners, immunosuppression, pregnancy, oral contraceptives are other causative factors for BP. The disease affects both sexes equally and is typical of young, sexually active people, aged between 20 and 40.Clinical features of BP are solitary or multiple confluent rapidly increasing papules with red-brown colour and diameter 2–10 mm, with uneven papillary or flat-to verrucous surface. They are localised on external genitalia bilaterally and symmetrically. In men cover foreskin, glans penis, in women labia majora, perianal area. This histology make difficult differential diagnosis with Morbus Bowen in anogenital area. Conducted destructive treatment in outpatient settings is with unsatisfactory therapeutic effect.
Methods We report the case of 45 year old female who addressed our clinic for multiple confluent papules with red-brown colour and diameter 2–10 mm., with uneven papillary or flat-to verrucous surface on external genitalia area bilaterally and symmetrically.
Results Histologic examination of a biopsy specimen established acanthosis, parakerathosis, hyperkerathosis, koilocytosis and atypical cells with hyperchromic bi, multinuclei occupying almost half the thickness of the epidermis to the extent of bowenoid dysplasia.

Conclusion The patient was treat with Imiquimod 5% cr. for 8 weeks with non significant results an partial vulvectomy (willingness of the patient) was performed.

P2.56 A REMINDER FROM THE GREAT IMITATOR – GUMMATOUS SYPHILIS OF THE NASAL CAVITY WITH SEPTAL PERFORATION

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Introduction Gummatous syphilis presenting as nasal septal perforation is well described in the classic literature, but rarely encountered in the current antibiotic era. We present a man with a destructive nasal process with a delayed diagnosis of tertiary (late benign) syphilis.

Case Description A 45 year old Eritrean gentleman presented with an ulcero-nodular lesion of the left nares, progressive over the previous six months. He denied trauma or illicit drug inhalation. Exam was remarkable for left nasal cavity with an eroding destructive lesion perforating through the nasal septum and left nasal ala. He had no clinical signs or symptoms of neurosyphilis. Multiple biopsies revealed acute-on-chronic inflammation with focal necrosis and no evidence of malignancy. Fungal, treponemal and routine bacterial stains were negative, and tissue cultures were negative. Imaging indicated no bony destruction. The patient was treated for presumed cellulitis with multiple courses of oral antibiotics (cephalexin, amoxicillin) with no improvement in symptoms. At follow up, the patient tested negative for human immunodeficiency virus (HIV) infection and negative for anti-neutrophil cytoplasmic antibodies (ANCA). Serologic tests for syphilis were ultimately performed, revealing a rapid plasma reagin (RPR) titer of 1:512 with a reactive florescent treponemal antibody absorption test (FTA-ABS). A CSF evaluation was normal, with no pleocytosis and normal protein and glucose. Treatment was initiated with benzathine penicillin G, three doses of 2.4 million units each at one-week intervals. Clinical response to treatment is pending at the time of this report.

Discussion Gummatous syphilis is of clinical importance because of its potential for local destruction and disfigurement of the nasal structures. Early recognition and management has important individual and public health implications and this case would remind contemporary physicians that "the great imitator" could lurk behind unusual presentations.

P2.57 A CASE OF DIFFICULT DIAGNOSIS: NEUROSYPHILIS IN HIV INFECTED PATIENT

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Introduction It is known that HIV infected patients with syphilis are more prone to invasion of *T. pallidum* into central nervous system. Moreover, the diagnosis of neurosyphilis in HIV infected patients can be particularly difficult and challenging since serological tests in the cerebrospinal fluid (CSF) can often be false negative.

Case report A previously healthy 40- year- old male was admitted to neurology department due to acute left side paresthesia, ataxia and diplopia. Since his head CT and CT-angiography scans were without pathological findings and his symptoms started recovering, he was treated conservatively. His symptoms worsened the next day and MR scan revealed right posterior pontine infarction. As part of routine screening for stroke in young patients, he was tested for HIV and syphilis. Serologic tests for syphilis were positive in serum as were screening and confirmatory tests for HIV infection. CD4+ cell count was 282/mm^3 and HIV RNA was 9480 copies/ml. CSF analysis showed elevated protein level (0,70 g/L) and lymphocytic pleocytosis (lymphocytes 30/mm^3). CSF- RPR and CSF-TPHA were not reactive. However, because of strong clinical suspicion of meningovascular syphilis, additional serological tests for syphilis in CSF, i.e. CSF-IgG-FTA-ABS and CSF-LIA (Line Immuno Assay), were performed: both were positive. After the confirmation of suspected meningovascular syphilis, treatment with intravenous benzylpenicillin was given for 21 days. Neurological symptoms subsided and patient was discharged with minimal neurological sequelae.

Conclusion The correct diagnosis of neurosyphilis in HIV infected patients presents a challenge since serologic tests can be false negative. Therefore, different serologic tests with high specifity and sensitivity should be used, newer tests such as LIA and CIA being particularly helpful. Clinicians should be aware of the characteristics of syphilis and HIV coinfection to establish the correct diagnosis and provide adequate treatment, which will minimise neurological impairments among these patients.

LB 2.58 DRUG RESISTANCE MUTATIONS IN HUMAN IMMUNODEFICIENCY VIRUS TYPE 2 (HIV-2) STRAINS FROM PATIENTS IN GHANA

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Introduction The Human Immunodeficiency virus (HIV) epidemic is characterised by the dominance of HIV type 1 (HIV-1) worldwide. Consequently, antiretroviral therapy (ART) and drug resistance studies have focused almost exclusively on HIV-1. In Ghana both HIV-1 and HIV-2 co-circulate with lack of data on HIV-2 drug resistance mutations. We sought to determine drug resistance mutations in HIV-2 patients in Ghana.

Method We used purposive sampling to collect blood from 16 consented patients confirmed as HIV-2 and dual HIV-1/2 by serology and molecular assays. Real-time RT-PCR assay was used to determine the viral load of patients by using an HIV-2 RNA International Standard from the National Institute for Biological Standards and Control (NIBSC). Nucleic acid (RNA and DNA) were extracted from plasma and peripheral blood mononuclear cells (PBMC) respectively. The reverse transcriptase (RT) and protease (PR) genes of HIV-2 were amplified