Methods A retrospective chart review of all patients seen at the Anal Dysplasia Clinic at the Pittsburgh AIDS Center for Treatment was performed between 1 January 2008 and 30 June 2010. 41 HIV positive MSM had biopsy proven HGAIN (AIN1/2, AIN2, AIN 2/3, and AIN3) at high-resolution anoscopy. Treatment involved applying three sequential cotton swabs soaked in 80% TCA to the lesion. Patients were seen at an average of 6 months following treatment for follow-up. Clearance was defined as the absence of HGAIN epithelial markers at HRA (punctuation/mosaicism) or AIN 1/normal epithelium on biopsy. The impact of the following variables on lesion clearance were assessed using univariate logistic regression analysis: age, CD4 count, initial grade of dysplasia on biopsy, concomitant therapy with imiquimod, previous history of HGAIN treatment.

Results The mean age of the study population was 52 years and the mean CD4 count was 565 cells/ml. Of the 43 HGAIN lesions treated in 41 patients, 22 (51%) demonstrated clearance of HGAIN epithelial markers. Repeat biopsy was performed on eight lesions and four (9%) lesions were AIN1, 5 (7%) lesions were AIN2, and one lesion was ungradable. By univariate logistic regression analysis, patients with a diagnosis of AIN1/2 (compared with those who had AIN2 or greater) demonstrated a non significant trend towards clearance of abnormal visual markers (OR 5.8: p=0.112). All other predictive variables did not achieve statistical significance.

Conclusions On a per lesion basis, the success of a single visit triple topical application of TCA was 50% that is comparable with previously published treatment studies using techniques such as infrared coagulation. While longer prospective studies are called for, following exclusion of cancer by biopsy, HRA combined with TCA treatment may represent a low-cost, minimally invasive management strategy for this population with a high-incidence of HGAIN.

Poster Sessions

P3-S4.06 MEN WITH GENITAL WARTS DO CONSULT LATER THAN WOMEN

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P Dolcié, V Séguin, H Bernatchez. CSSS Rimouski-Neigette, Rimouski, Canada

Background CSSSRN is a regional hospital of 240 acute-care beds with a STD clinic which works mainly with clinical nurses, under the supervision of Infectious Diseases physicians (ID). This study aimed to review the clinical data of patients with genital warts.

Methods All files from patients with genital warts evaluated in our STD clinic between 2005 and 2010 were reviewed for clinical data including the delays before consultation. All data were analysed with Epi Info 3.5.2.

Results From 2005 to 2010, an average of 5950 patients per year attended our STD clinic, and 70% were women. A total of 656 cases of genital warts were diagnosed by visual inspection from the attending ID physician. The specific types of lesions were warts associated with Human Papilloma Virus in 76%, molluscum contagiosum 20%, both 4%. The median age was 24 years (range 16–76) and 57% of patients were men. The patients did not notice any lesion prior to consultation in 61 cases (9.3%). For the others, the delays before consultation were: 0–7 days (16.2%); 8–14 days (9.8%); 15–27 days (12%); 1–2 months (50%); 3–5 months (11.5%); 6–12 months (11.5%); >1 year (2.7%). Significant longer delays before consultation were observed for men in comparison to women. The delays were: ≤7 days (men 42/349 [12%], women 54/244 [22.1%, p<0.001]; =14 days (men 70/349 [20.1%], women 79/244 [32.4%, p<0.001]; =27 days (men 113/349 [32.3%], women 107/244 [45.8%, p=0.006); ≥6 months (men 90/349 [25.7%], women 33/244 [13.5%, p<0.001); more than 1 year (men 41/349 [11.7%], women 11/244 [4.1%], p=0.002).

Conclusions In our population, the median delay before consultation for genital warts was 1–2 months. However, men with genital warts do consult significantly later than women. Specific public health approach should be considered for men with visible genital lesions, in order to promote earlier consultation and limit transmission. More behavioural studies are needed to further investigate this observation.

Clinical sciences poster session 5: other

P3-S5.01 MICROBIAL DIVERSITY OF GENITAL ULCER DISEASE IN MEN ENROLLED IN A RANDOMISED TRIAL OF MALE CIRCUMCISION IN KISUMU, KENYA

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1S Mehta, 2J Maclain, 1R Baiely, 2S Moses, 3P Gillevet, 4G Spear. 1University of Illinois, Chicago, USA; 2University of Manitoba, Winnipeg, Canada; 2Chronic Disease Prevention and Control, Health Canada, Winnipeg, Canada; 3AIDS Research and Prevention Foundation, USA; 4Rush University, USA

Background Medical male circumcision (MMC) reduces the risk of HIV acquisition by ~60%, in part by reducing genital ulcer disease
(GUD) and HSV-2. In the Ugandan and Kenyan trials, PCR did not find a sexually transmissible agent in 50–60% of GUD specimens, and MMC did not protect against HSV-2 in the Kenyan trial. We sought to better define the aetiology of GUD in the Kenyan trial and examine how MMC affects GUD aetiology.

**Methods** We defined GUD of unknown aetiology as negative for HSV type 1 and type 2, T pallidum, and H ducreyi by PCR, and negative for HSV-2 and T pallidum by serology. In 59 GUD specimens from 59 men, 25 (39%) had unknown aetiology. We identified bacterial microbiota in all 59 specimens using multitag pyrosequencing of the 16S rRNA gene, and compared results by unknown vs STI aetiology. Statistical analysis employed exact methods.

**Results** Overall, 83 distinct genera were detected. Prevotella spp. was most abundant, accounting for 18% of microbiota on average, and present in 75% of specimens. Bacterial diversity was greater in GUD of unknown aetiology than STI associated GUD (median number of genera 13 [range 7–20] vs 11 [range 3–20], p = 0.06). Fusobacterium spp., Sneathia spp. and Anaerococcus spp. were more abundant in GUD of unknown aetiology (7.7%, 7.6%, and 7.3%, respectively) than in GUD of STI aetiology (4.6%, 5.0%, and 5.4%). Fusobacteriales (Fusobacterium spp. or Sneathia spp.) [OR = 4.7, 95% CI: 1.3 to 19.9] and Anaerococcus spp. [OR = 4.6, 95% CI: 1.2 to 22.5] were more likely to be recovered in GUD of unknown aetiology than STI associated GUD. Fusobacteriales were more often recovered from uncircumcised men than circumcised men (62% vs 22%, p = 0.04), and Anaerococcus spp. was present in 22% of circumcised vs 70% of uncircumcised men (p = 0.010). Reported penile coital injuries were more common among men with Anaerococcus spp. (85% vs 57%, p = 0.01), and condom use was less common (50% vs 71%, p = 0.11). There was no difference in these bacteria by ulcer location.

**Conclusions** Fusobacteriales and Anaerococcus spp. may colonise genital ulcers that develop from a mechanism related to circumcision status. Many such “ulcers” may be epithelial disruptions that are traumatic in origin. These bacteria have cytotoxic properties that may ulcerate or exacerbate pre-existing minor epithelial disruptions. MMC may reduce GUD through a reduction in these anaerobic bacteria.