Table 1 details respondents' reported competencies and training availability in 2010 curriculum skills.

Abstract P165 Table 1

	Competent (%)	Not competent, training available (%)	Not competent, training not available (%)
Emergency contraception counselling	100	0	0
Referring to support organisations	90	10	0
Prescribing STI/HIV/Hep B prophylaxis	90	10	0
SV history taking and risk assessment in u-18s	89	4	7
Forensic exam counselling/ documenting injuries	64	29	7
Documenting history/exam for medico-legal report	46	19	35

Conclusions Wide variation exists in reported SV experience, training received and training availability, in the 28% of trainees responding. Regular accessible training is needed in identifying and managing patients disclosing SV.

P166 INCREASING SCREENING FREQUENCY IN MEN WHO HAVE SEX WITH MEN (MSM): IMPACT OF EXPLICIT GUIDANCE ON RISK PROFILING ON UK SERVICE

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Background STI and HIV diagnoses are increasing among MSM. Mathematical modelling shows increasing screening frequency can reduce STI prevalence, especially targeting MSM engaging in risk behaviours. International guidelines from both the CDC and Australasian Society for HIV Medicine clearly define risk behaviours with adapted screening intervals—contrary to the UK where NICE guidance is vague.
Objectives To investigate impact of applying stricter international screening guidelines for MSM, on service workload and earlier STI diagnosis in a UK level 3 service [L-3S].
Methods A validated risk questionnaire distributed to MSM attending a large provincial L-3S over a 3-month period explored their actual screening frequency, STI diagnoses and risk behaviours in the prior 12 months. Australian screening guidelines were applied to the data to identify MSM needing more frequent screening. Projections to the larger MSM population attending over 12 months were modelled, based on the demographics of the respondents.
Results 126/357 completed the questionnaire, 89 were identifiable. There was no statistically significant difference between STI rates (p=0.18) and HIV diagnoses (p=0.62) between identifiable questionnaire respondents and other MSM clinic attendees. Demographic analysis showed the sample group was representative of the larger cohort. In 2011, applying Australasian Society for HIV Medicine risk profiling for the 793 MSM who attended the unit, 26% would require one additional 6-monthly attendance for HIV screening, while 6% would require two visits. Additional STI screening visits would be needed by 25% (1 visit) and 10% (2 visits). 29% of STI diagnoses were in infrequent attendees.
Conclusions Stricter UK screening guidelines for MSM defining and weighting risk behaviours explicitly in line with other international guidelines, would increase L-3S MSM visits by 30% and potentially diagnose a large proportion of disease earlier. In light of the results UK guidelines may benefit from review.

P167 MANAGEMENT CHALLENGES OF A TRIFECTA (HIV, HEPATITIS C AND SYPHILIS TRI-INFECTION) AND AN UPDATE ON HIV/HCV CO-INFECTION

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This complex case is of an ageing HIV positive patient, who had been a management challenge to a multidisciplinary team over the past decade in Adelaide, South Australia. He had various comorbidities and had developed various other infections, mostly sexually acquired, complicating his management. The patient was diagnosed as HIV positive in 1985 and commenced on HAART in 1989. He relocated to Adelaide in 2002. His major issues at that time were sexual dysfunction and bipolar affective disorder. On routine screening mid 2005, his CD4 count had dropped. Liver function tests were abnormal with raised GGT, ALT and AST. Subsequently, he was found to be Hepatitis C positive (Genotype 3). He adamantly denied intravenous drug use but had unprotected anal intercourse with other men. He also had a Prince Albert ring inserted. The hepatitis C infection was apparently acquired sexually. He proceeded to have multiple sexual partners interstate and overseas. On return to Adelaide at the end of 2005, he was found to be syphilis EIA positive, RPR 1:32 and FTA IgG positive. He was treated with benzathine penicillin. Management of his hepatitis C initially involved changes to his HAART over the next 2 years before he finally decided to commence interferon and ribavarin therapy for his Hepatitis C co-infection. He was on treatment for 6 months, with close monitoring by the team psychiatrist in view of his psychiatric comorbidities. To date, he has maintained sustained virological response. An overview of HIV/Hepatitis C co-infection from recent literature review will also be presented.

Clinical case reports

P168 ACUTE GENERALISED EXANTHEMATOUS PUSTULOSIS INDUCED BY PNEUMOCYSTIS CARINII PNEUMONIA (PCP) PROPHYLAXIS WITH DAPSONE

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Background Acute generalised exanthematous pustulosis (AGEP) is a severe cutaneous adverse reaction. Most cases are drug related, however the condition has been associated with viral infections.
Objective AGEP in the setting of HIV is uncommon. We report a case of AGEP induced by PCP prophylaxis with dapsone.
Results A 34-year-old HIV-infected Nigerian woman was admitted to hospital with a 2-week history of a progressing pustular skin rash. CD4 count 1 month prior to admission was 176 cells/mm^3 and she had not been taking antiretrovirals since 2008. Three weeks prior to presentation she had commenced Dapsone for PCP prophylaxis. Admission to hospital revealed a fever of 40°C, tachycardia, hypotension and a widespread erythematous papular eruption with overlying pustules. Laboratory investigations revealed; haemoglobin 7.6 g/dl, raised oeosinophils of 0.67×109/l, C reactive protein 144 mg/l and Direct Coombs test was positive. A venous methaemoglobin level was raised at 3.5% and chest radiography revealed subtle consolidation at the left base. Broad spectrum antibiotics and fluids were initiated and Dapsone was withdrawn. Dermatology review raised the clinical suspicion of drug rash with oeosinophilia and systemic symptoms (DRESS) or AGEP. Skin biopsy supported the clinical diagnosis of AGEP. She remained systemically unwell

and intravenous hydrocortisone was commenced. Subsequent infective screen for viral and bacterial pathogens was negative. Over the following week the pustular rash began to desquamate with significant improvement. She made a full clinical recovery and subsequently started antiretroviral therapy and atovaquone for PCP prophylaxis.

Discussion Drug reactions in the setting of HIV and its treatment are common. AGEP in the setting of HIV has rarely been reported. This case illustrates a less common but important severe cutaneous adverse reaction to recognise in our HIV cohort.

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P169 DON'T WHIP IT OUT UNTIL SYPHILIS IS RULED OUT

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Introduction Discrete syphilitic lesions mimicking testicular tumours are reported in the literature but usually diagnosed after removal of the testes in conjunction with positive syphilis serology. We present the first case, to our knowledge, in which a discrete testicular mass in the context of positive syphilis serology has been spared surgery and resolved both clinically and on serial ultrasound scans following antibiotic therapy.

Case A 47-year-old gentleman attended GUM clinic with inflammation under his foreskin and was found to have painless testicular lump on examination. Initial ultrasound revealed a 2 cm well defined, hypoechoic mass within the right testes. He was referred to urology on suspicion of malignancy. Subsequent Syphilis serology was positive and the penile lesion and testicular mass were felt to be consistent with syphilis. After liaising with the urology department, and in view of negative tumour markers (LDH, AFP and HCG) and known penicillin allergy, he was managed conservatively with doxycycline. Follow-up ultrasound scans at 1 month and 4 months revealed good resolution of the testicular mass. The last scan performed at 10 months after treatment revealed complete resolution.

Conclusion The case illustrates that syphilis needs to be considered in the differential diagnosis of testicular lumps and that conservative management with close follow-up can spare the patient radical orchidectomy.

P170 A CLINICAL CASE STUDY OF THE USE OF MOTIVATIONAL INTERVIEWING (MI) TO ADDRESS A HIV+ GAY MAN'S SEXUAL RISK TAKING AND RECREATIONAL DRUG USE

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Background There is an increased prevalence of many sexually transmitted infections (STIs) among HIV+ gay men. In addition, the increase of the use of recreational drugs within this population is associated with increased sexual risk taking. There is a need for specific services to address sexual risk taking within this population. A clinic was set up to deliver an MI based intervention to gay men who engage in "high risk" sexual activity, including unprotected anal intercourse. This is a case study of one of the patients referred to this clinic.

Aims The patient is a 47-year-old gay man with a long standing diagnosis of HIV; he has had a number of other STI's in the past. He was engaging in a high frequency of unprotected anal intercourse (both single partner and group sex) with partners he met on the internet. He reported always using recreational drugs during sex sessions. The aim of the intervention was to reduce the frequency of the patient's unprotected sex, thereby reducing patient's risk of acquiring and/or transmitting STIs.

Methods Intervention consisted of five individual sessions of MI with a Clinical Psychologist over a period of 3 months.

Results After five sessions, the patient reported discontinuation of all recreational drugs, a reduction in the volume of sexual encounters, an improvement in mood and increased satisfaction with his sex life.

Discussion This clinical case study provides preliminary data to support the value and the appropriateness of MI for sexual risk reduction coupled with recreational drug use. Despite the level of complexity of the patient's presenting problems, MI proved to be an effective intervention. Further research is needed to investigate the efficacy of MI for sexual risk reduction with this population.

P171 A CASE OF EXTENSIVE ORAL AND PENILE ULCERATION

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A 35-year-old Indian man was referred to the genitourinary clinic with a 3-month history of progressive, painful oral and penile ulceration. He had lost 10 kg in weight. He was anorexic secondary to mucosal pain but was otherwise well, with no reported rashes or eye problems. He had no significant medical history and took no regular medication. Last sexual intercourse was protected vaginal intercourse with a commercial sex worker 10 weeks earlier. On examination of the mouth, extensive ulceration was seen on the buccal mucosa and tongue; genital examination revealed superficial erosions on the glans penis and prepuce. Examination of the eyes, skin and joints was unremarkable. The differential diagnosis included: erosive lichen planus, aphthous ulcers, pemphigus vulgaris, cicatricial pemphigoid, Behçet's disease and secondary syphilis. Swabs from the oral ulcers were positive for Herpes simplex virus (HSV) type 1 DNA but penile swabs were negative for both HSV type 1 and 2. Hepatitis B, C, and syphilis serology, HIV antibody, and autoimmune profile were negative. Indirect immunofluorescence for epithelial intercellular cement was positive at a titre of 1:160. Biopsy of the oral lesions showed marked suprabasal acantholysis with prominent Tzank cell formation, in keeping with pemphigus vulgaris (PV). The patient was maintained on oral prednisolone with gradual improvement. Azathioprine will be used as a long-term steroid sparing agent. PV is a potentially fatal autoimmune blistering disorder of the skin and mucous membranes, more common in Indians. Cutaneous lesions are often absent. HSV can both mimic immunobullous disorders and cause superinfection. Therefore, positive HSV swabs must be taken in context and interpreted carefully. Patients may present to the GUM clinic with a history of mucosal ulceration and PV should be included in the differential of such cases.

P172 TRANSMITTED DRUG RESISTANT HIV PRESENTING AS SEVERE ENCEPHALITIS

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Background Selection of the K103N mutation is associated with a small but significant reduction in viral replicative fitness. Therefore it could be hypothesised that transmission of this strain could be associated with minimal symptoms and low level viraemia at HIV seroconversion.