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.

09 Clinical case report

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.

Case We present the case of a 41-year-old MSM who was admitted with fever, confusion and agitation following unprotected anal sex 6 weeks earlier with a man of unknown HIV status. He required intubation due to the level of agitation. Admission CT and MRI brain were unremarkable. The first test HIV test was weakly antibody positive; a repeat 6 days later showed a stronger antibody response consistent with HIV seroconversion. His baseline CD4 count was 138 (18%); HIV viral load was 929 000 copies/ml. CSF analysis showed 4 white blood cells, elevated protein at 1.2 g/dl, and a normal CSF to plasma glucose ratio. There was insufficient CSF sample for HIV viral load testing. A diagnosis of encephalitis secondary to HIV seroconversion was made and antiretroviral therapy (ART) with five drugs was started on day 3 of admission. The patient remained agitated for several days. By day 21 the seroconversion symptoms had fully resolved, and by day 28 the plasma HIV viral load was undetectable. Viral genotyping showed the K103N mutation only. The patient remains on ART; now simplified to Kivexa, Darunavir and Ritonavir. This is to continue for 48 weeks at which point a decision will be made to either stop treatment or to continue lifelong ART.
Conclusion Transmitted drug resistant HIV can cause severe seroconversion illness and high levels of viraemia despite lower viral fitness. To our knowledge, this is the first report of viral encephalitis at HIV seroconversion caused by drug resistant HIV. The role of entry inhibitors and integrase inhibitors for the treatment of severe seroconversion symptoms to prevent viral entry into cells and aid rapid decline in viraemia are currently under evaluation.

P173 CASE REPORT: RARE CAUSE OF ADULT ONSET SEIZURES IDENTIFIED IN AN HIV POSITIVE ADULT

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Case Report A 63-year-old male with a long history of poor social interactions presented acutely confused. There was no alcohol or recreational drug use. Baseline bloods and routine microbiology were normal. CT and MRI of the brain found no causative pathology. Lumbar puncture (LP) only revealed a raised protein (1.47). An HIV test was positive; CD4 170 cells/μl, viral load (VL) 238 281 copies/ml. The patient refused antiretroviral (ARV) treatment, depressive episode was diagnosed and mirtazapine commenced. Three days later he went into status epilepticus. A repeat MRI brain was unchanged and LP showed: protein 0.84; glucose 4; WBC 5/cmm; India ink, CRAG, virology, acid fast bacilli and cytology were negative. Seizures were unremitting and nevirapine and truvada were commenced and mirtazapine withdrawn: seizure activity ceased. Gradually he improved and his CD4 rose to 280 cells/μl, HIV VL <50. Despite treatment, the patient re-presented with seizures on several occasions. No trigger was identified, and reported ARV adherence good. Repeat investigations revealed no new abnormality. In the absence of an adequate explanation for seizures, neuroimaging was reviewed by a specialist neuroradiologist. Nodules within the frontal horns of the lateral ventricles were identified, indicating a diagnosis of subependymal nodular heterotopia (SNH).
Discussion This is the first report of SNH in an HIV positive adult. SNH are congenital, occurring during foetal neuronal proliferation and have no known association with HIV. Patients usually present in their 2nd decade with seizures and exhibit cognitive difficulties. SNH presenting in the 7th decade of life with status epilepticus is rare and we postulate that the cerebral atrophy associated with untreated HIV infection may have precipitated seizures in a predisposed individual. This case described demonstrates the importance including non-HIV related causes, when considering the aetiology of seizures in patients with HIV.

P174 THE TANGLED MESH OF LYMPHOGRANULOMA VENEREUM

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Introduction The HPA report an epidemic of lymphogranuloma venereum (LGV) among men who have sex with men in the UK since 2003. Untreated LGV may lead to chronic or irreversible complications with disabling anatomic defects. Reports suggest surgical intervention is rarely required.
Case 45-year-old man who has sex with men, diagnosed HIV positive in 1995, not on antiretroviral therapy due to patient reluctance, following intolerance to several previous regimens. He had spent the summer in Egypt and on return to the UK had a brief spell as an inpatient with campylobacter and norovirus diarrhoea. He presented to the GUM clinic reporting multiple high risk partners and was treated as a gonorrhoea, chlamydia and syphilis contact; STI screen negative. He re-presented a month later with severe proctitis; pain and blood per rectum and frequent small volume stool. Rectal chlamydia was positive and subsequently LGV serovars confirmed. He tested positive for hepatitis C, retrospective sampling of stored blood samples suggested that this had been recently acquired. Hepatitis C treatment was unsuccessful due to lack of virological response and he suffered acute psychosis likely secondary to pegylated interferon. Despite 3 weeks of doxycyline and negative chlamydia retesting he persisted with severe proctalgia and constipation and was referred to gastroenterology. Flexible sigmoidoscopy showed a single ulcer in the upper third of the rectum with the remainder of the colon looking normal. He received empirical retreatment of LGV, rectal predfoam and laxatives. Symptoms worsened and a defecating proctogram (video of proctogram available) identified marked anorectal intussusception. This was surgically managed with a mesh support inserted laparoscopically.
Conclusion Despite early recognition, treatment and apparent clearance of LGV infection complications can occur. This is the first report of complicating anorectal intussusception requiring surgical intervention with a mesh support.

P175 THE GREAT PRETENDER STRIKES AGAIN

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Background An epidemic of syphilis persists in UK men who have sex with men (MSM), often with unusual manifestations. We report a case of syphilis mimicking a lymphoproliferative disorder.
Case A 29-year-old previously well MSM was admitted with 3 weeks of generalised painless lymphadenopathy. He reported malaise, night sweats and joint pain while travelling recently in the Middle East. He was apyrexial and routine bloods were normal apart from mildly raised liver enzymes. Paul Bunnell and HIV antibody tests were negative. His GP screened for STIs but did not include syphilis serology despite the patient describing penile lesions. Clinicians felt that the presentation was highly suggestive of lymphoma. A CT scan showed multiple enlarged lymph nodes in the neck and small bowel mesentery. An open cervical lymph node biopsy was performed. Histopathology showed suppurating granuloma in a reactive lymph node with no evidence of lymphoma. Stains for HIV p24, acid-fast bacilli and fungi were negative. The suggested differential included lymphogranuloma venereum (LGV), cat scratch disease and melioidosis. At GU medicine review he reported sex with multiple partners in the preceding 6 months. He had a blotchy maculopapular rash on his penis and scrotum, though this was treated as "fungal" by junior staff. Molecular tests for