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

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**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.

**P174 THE TANGLED MESH OF LYMPHOGRAVLULOMA 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 doxycycline and negative chlamydia retesting he persisted with severe proctalgia and constipation and was referred to gastroenterology. Flexible sigmoidoscopy showed a small 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 ano-rectal 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 ano-rectal 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 a case of syphilis mimicking a lymphoproliferative disorder. 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.

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.