Since 2003 LGV outbreaks have been reported in different European cities in men who have sex patient men with high-risk sexual behaviours. In the majority of cases the most common clinical presentation was a rectal syndrome described as an acute proctitis. In Barcelona during 2012 the most common clinical presentation was proctitis, but revealed an increase in cases of LGV extrarectal location.

**Objective** To analyse LGV cases that have been diagnosed in 2012 in the reference STI Unit (UITTS) Drassanes of Barcelona.

**Methods** Retrospective descriptive study. Review of epidemiological data, clinical presentation, physical examination and results of mentioned cases has been conducted.

**Results** In 2012 fifty-two cases of LGV in UITTS were diagnosed, 8 of them in an extrarectal location. All of them were male: 50 were MSM and 2 bisexual men. Co-infection with HIV was 65%, decreasing to 50% in the extrarectal location. 11.5% of them had a history of LGV and 36.5% had a sexually transmitted infection in the previous 12 months. The most common clinical presentation was proctitis (65%), other clinical manifestations were urethritis, inguinal syndrome and anogenital ulcers. 21% were diagnosed by contact study (half for LGV and half for other STI) and one case was diagnosed by screening in an asymptomatic patient.

**Discussion** Although during the last years the typical presentation of LGV has been proctitis, the extrarectal location has increased considerably in 2012. In this situation it is necessary to assess whether or not to request it in a urethral syndrome as ulcerative lesions, especially in men who have sex with men with high-risk sexual behaviours.

**Conclusion** A low CD4 cell count at KS diagnosis is an important predictor for mortality.

**P2.127** PRESENTATION OF LYMPHOGRANULOMA VENEREUM (LGV) IN 2012 IN THE REFERENCE STI UNIT OF BARCELONA


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Lymphogranuloma venereum (LGV) in Europe emerged in 2003 affecting mostly MSM. Rectal primary LGV causing proctitis has been by far the most common clinical manifestation. In Barcelona, with a cumulative number of around 200 cases up to 2012, some cases have appeared with extrarectal manifestations since 2008. We report two cases in MSM with genital primary LGV mimicking primary syphilis.

**Case 1.** A 29-year-old HIV-positive man presented with a genital chancre and inguinal lymphadenopathy of 10 days’ duration. He reported 5 casual partners the last 3 months. Although dark-field exam was negative the patient was treated with benzathine penicillin G 2.4 million units. He was seen 4 days later without improvement, with buboes and genital edema. A swab from the ulcer was positive for LGV and negative for syphilis and chancroid by PCR. A diagnosis of bubonulosis was made, and the patient started doxycycline 100 mg/12 h for 21 days. He improved persisting a small residual soft mass on the shaft of the penis.

**Case 2.** A 37-year-old HIV-negative man presented with a genital ulcer and lymphadenopathy of 2 days’ duration. He had multiple unprotected casual partners in sex parties 3 days before. Three consecutive dark-field exams were negative. Five days later the ulcer persisted like a chancre and inguinal buboes were more evident. LGV was detected from the ulcer while syphilis and herpes were negative by PCR. The clinical manifestations resolved quickly after completion of treatment with doxycycline as above.

Cases with non-rectal lesions would be expected as LGV spreads. When present, the most common presentation of the primary lesion in the genitalia is a nonindurated herpetiform evanescent ulcer. Clinicians must be vigilant to the evolving faces of LGV, prepared to recognize the full manifestations of this disease and consider LGV in the differential diagnosis of genital chancr.