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 previous LGV and 36.6% 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.
The age of these patients ranged from 20–44 years. The patients presented with cord-like thickening on penis within 24–48 hours after a prolonged sexual act with or without an intercourse. Seventeen patients had history of one or more episodes of STDs at presentation or in the past. Histopathological specimens showed prominent vessels with plump endothelial cells and thickened blood vessel walls. Occasional vessel showed complete occlusion of its lumen. Doppler US done in 10 patients showed dorsal vein thrombosis without the flow signals in this area. Patients were treated with counselling, abstinance and paracetamol. Thirty patients had resolution of the swelling by 6–8 weeks with treatment only two patient required surgery. No recurrence or erectile dysfunction was noted in any of the patients in the follow up from 2 to 8 years.

Conclusions Penile Mondor’s disease has a favourable evolution and functional prognosis; although various etiologies have been proposed; trauma caused by sexual intercourse or masturbation is the main etiologic factor. Doppler US is a non-invasive diagnostic modality helpful in both diagnosis and follow-up, however further analysis of Doppler US findings in a larger number of cases needs to be done to elucidate the hemodynamic changes in this not so rare entity.

**A CLINICO-AETIOLOGICAL AND ULTRASONOGRAPHIC STUDY OF PEYRONIE’S DISEASE**

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**Background** Peyronie’s disease (PD) is caused by progressive fibrotic scarring of the tunica albuginea resulting in curvature or other deformities of the erect penis. PD is a psychologically and physically devastating disorder that manifests in middle-aged men. Although long recognised as an important clinical entity of the male genitalia, the aetiology of this disease is poorly understood.

**Methods** In this retrospective analysis we studied the epidemiology and clinical presentation of PD cases presenting to the dermatology outpatient during Jan2001 - Dec2010. Diagnosis of PD was based on medical and sexual history, physical examination and imaging examinations: ultrasound, and colour Doppler ultrasound.

**Results** Fifty-six men with PD presented during the period of ten years. Their ages ranged from 23 to 70 years. Most of them presented during the early phase of the disease. Most common presenting complaint was penile curvature in 80.95% followed by pain on erection in 66.66%. History of penile trauma was revealed by 9.52% of patients. Hypercholesterolemia (60%), hypertension (53.3%) and asymptomatic hyperuricemia (28.34%) were the most common risk factors. Fifty patients with PD were studied by ultrasonography. Ultrasonogram was more accurate than clinical assessment in delineating the extent of lesions. In one-third of the patients, sonography demonstrated the plaques to be more extensive than had been detected by clinical examination.

**Conclusions** PD is a fibrotic wound-healing disorder involving the tunica albuginea of the corpora cavernosa leading to a variety of deformities of the genitalia which are associated with significant sexual dysfunction. The clinical symptoms and signs in our study were, in general, similar to those found in the previous studies. Higher incidence of hypertension and hypercholesterolemia in patients with PD may also be to an extent due to patients being in an older age group. However, it is difficult to explain asymptomatic hyperuricemia.

**PHARYNGEAL AND CONJUNCTIVAL CHLAMYDIA TRACHOMATIS INFECTIONS: CHICKEN OR EGG?**

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**Background** Chlamydial inclusion conjunctivitis caused by genital serovars of *Chlamydia trachomatis* (CT) is well-recognised, and usually thought to result from auto-inoculation from genital CT infection or direct sexual contact. In this case series we review nine patients with co-existing pharyngeal and conjunctival CT infection and hypothesise on the relationship between the two conditions.

**Methods** Retrospective analysis of 9 patients with pharyngeal and conjunctival CT infection. Diagnoses were made based on clinical findings and the detection of CT RNA by the Aptima Combo2 assay (Gen-Probe).

**Results** We found 9 cases of coexisting pharyngeal and conjunctival infection in men: 8 were men who have sex with men (MSM) and 1 was heterosexual. All but one MSM had participated in both receptive and insertive oral sex, with the final patient reporting insertive oral sex and rimming.

All patients were symptomatic with unilateral conjunctivitis; one had symptoms bilaterally. Four of the 9 patients had a normal anogenital examination, and only 1 patient had a sore throat. Six of nine patients also had rectal CT infection, with 1 equivocal rectal CT result. Only two patients had co-existing urethral CT infection. Two patients had solely pharyngeal CT, including the heterosexual man.

**Conclusions** While traditionally thought to be a result of auto-inoculation from genital CT infection, we speculate that pharyngeal CT infection might be a more common source, or even a sequela, of CT conjunctivitis - at least in MSM. Alternatively, CT detected in the throat might be secondary to drainage of lacrimal fluid from a CT-infected eye. As CT conjunctivitis might be treated in isolation without comprehensive CT screening, or at most, with genital CT testing alone, we feel pharyngeal CT testing is indicated in all patients with CT conjunctivitis. The role of the nasolacrimal duct as a potential two-way conduit of infection requires further investigation.

**PLASMA CELL BALANITIS (PCB), A CLINICO-PATHOLOGIC STUDY OF 132 CASES**

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**Background** PCB also known as Zoon balanitis, is a benign asymptomatic but chronic and erosive inflammatory condition of glans penis and prepuce that generally affects uncircumcised men in later years. Clinical presentation involves usually a single, shiny, well demarcated, red patch. Disease may persist for years which adversely affects the quality of life of the individuals.

**Methods** 132 patients with a clinical diagnosis of PCB were studied between 2001–2010. Biopsy was done in patients who agreed for the procedure. Patients who did not agree for circumcision were prescribed fluticasone cream or tacrolimus 0.1% and were followed up.

**Results** At a mean age of 55 years, PCB was more common in men who practiced receptive and insertive oral sex, with the final patient reporting receptive oral sex and rimming.

**Conclusions** While traditionally thought to be a result of auto-inoculation from genital CT infection, we speculate that pharyngeal CT infection might be a more common source, or even a sequela, of CT conjunctivitis - at least in MSM. Alternatively, CT detected in the throat might be secondary to drainage of lacrimal fluid from a CT-infected eye. As CT conjunctivitis might be treated in isolation without comprehensive CT screening, or at most, with genital CT testing alone, we feel pharyngeal CT testing is indicated in all patients with CT conjunctivitis. The role of the nasolacrimal duct as a potential two-way conduit of infection requires further investigation.