

## Abstracts

**Results** 64 patients participated (median CD4 417/mm<sup>3</sup>, range 84–1100). 50 of the patients were treated with single dose BPG. Only one patient had ANS (prevalence 1.56% 95 CI 0.04–8.4) with CSF RPR negative, CSF TPPA 1:1280 and lymphocytes 45/mm<sup>3</sup>. Two patients had a pleocytosis (50 and 22 white cells/mm<sup>3</sup> respectively) with negative CSF RPR and CSF TPPA and thus did not meet diagnostic criteria for ANS per protocol.

**Discussion/conclusion** Our study suggests that single dose BPG is effective treatment for early syphilis in HIV co-infected patients. We will present more data to support this conclusion.

### 033 AEROBIC VAGINITIS: PREVALENCE, MANAGEMENT AND OUTCOMES IN A LARGE INTEGRATED SEXUAL HEALTH CLINIC

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**Background/introduction** Aerobic vaginitis (AV), a syndrome of abnormal vaginal microflora, was first described in 2002 and is increasingly recognised as a condition distinct from bacterial vaginosis that may require different management.

**Aim(s)/objectives** To describe the prevalence of moderate-to-severe AV, its management and outcomes in a UK setting.

**Methods** We included all women presenting to our large integrated sexual health service who met criteria for gynaecological examination and near-patient microscopy. A single biomedical scientist scored the wet mount according to the method of Donders *et al.* If the score was 5 or above (indicating moderate to severe AV) the requesting clinician was informed. We reviewed case notes to determine treatment choice and outcome.

**Results** From 1/12/13 to 30/11/14, 1616 wet films were read. Overall, 314 (19.4%) had an abnormal AV score (11 (0.7%) severe AV (score >6), 61 (3.8%) moderate AV (score = 5–6), 253 (15.7%) slight AV (score = 3–4)). Patients with severe AV were significantly older than those with moderate AV (mean age 42.7 vs 32.0 years,  $p = 0.04$ ), but only 6 (8.3%) patients had atrophic change. Among patients with AV scores of 5 or more, trichomonas was seen in 2 (2.8%) patients, 13 (18.5%) had evidence of yeast infection. First-line treatment included intravaginal clindamycin (49.7%), oral metronidazole (27.3%), antifungals, penicillins, acidification gel and local oestrogen. Symptoms persisted in 19.4%, re-occurred in 4.2% and resolved in 43%, with 33% not re-attending.

**Discussion/conclusion** Patients with moderate-to-severe AV scores are challenging to manage with a high proportion of repeat attendance. Severe AV occurs in an older population.

## Clinical Case Studies: 2<sup>nd</sup> June 2015

### C1 CASE SERIES: MANAGING DESQUAMATIVE INFLAMMATORY VAGINITIS IN TRANS-MEN

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**Background/introduction** Desquamative inflammatory vaginitis (DIV) is an uncommon condition characterised by florid vaginal inflammation causing vaginal discharge, vulval pain and dyspareunia. Microscopy typically shows absent vaginal flora, numerous polymorphs and immature parabasal cells with no mature epithelia. The pathogenesis of DIV is currently unknown but may involve tissue kallikrein-related peptidases which are regulated by sex hormones and corticosteroids.

**Case-1:** 35-year-old trans-man on testosterone for 18-months presenting with yellow vaginal discharge, vestibular pain and dyspareunia. Examination revealed vaginal inflammation and mucopurulent discharge. Microscopy was typical of DIV. He was treated with intravaginal clindamycin reporting a good response.

**Case-2:** 26-year-old trans-man on testosterone for 7-years presenting with vaginal discharge, dyspareunia and post-coital bleeding. Examination revealed inflamed friable vaginal mucosa. Microscopy findings were typical of DIV and he started treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

**Case 3:** 20-year-old trans-man with vaginal discharge and post-coital bleeding who started testosterone 6-months earlier. Examination and microscopy findings were typical of DIV. He commenced treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

**Case 4:** 19-year-old trans-man on testosterone for 9-months presenting with vaginal pain and bleeding. Examination and microscopy were typical of DIV. He started treatment with intravaginal clindamycin (partial-response) and switched to intravaginal prednisolone.

**Discussion** We present four cases of DIV in trans-men possibly associated with androgens responding to intravaginal clindamycin and steroids. As well as causing significant morbidity DIV may increase transmission of sexually-transmitted-infections in trans-men: we need to understand more about its aetiology, management and long term outcomes.

### C2 GONOCOCCAL TENOSYNOVITIS IN TWO HIV-INFECTED HETEROSEXUAL MALES: DELAYED DIAGNOSES FOLLOWING NEGATIVE URINE NAAT TESTING

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**Background** Disproportionately high gonococcal incidence rates amongst men have altered the clinical picture of disseminated gonococcal infection (DGI). The ‘classical’ female patient experiencing a triad of arthritis, tenosynovitis and cutaneous lesions no longer predominates. We present two cases emphasising the need for thorough investigation with evident clinical signs of DGI.

**Cases** A 48 year old Nigerian heterosexual male presented with a 6 cm inguinal mass and oral hairy leukoplakia. Impression was of lymph node abscess; HIV testing was positive. Urine Nucleic Acid Amplification Testing (NAAT) for chlamydia and gonorrhoea (CT/GC) was negative. Subsequently he developed a swollen tender left wrist. Inguinal abscess aspiration for NAAT testing returned a positive gonococcal result. Treatment was instigated with intravenous ceftriaxone for 4 days, subsequently switching to cefixime for a further week. 3 weeks later his wrist swelling resolved.