A 50 year old HIV-positive British heterosexual male presented after returning from Thailand. He had developed a tender swollen left wrist. Urine NAAT for CT/GC was negative. He reported condomless oral and vaginal sex with multiple Thai females. Gonococcal tenosynovitis was suspected and extragenital NAATs and cultures for CT/GC were taken; NAAT for pharyngeal gonorrhoea was positive. Single dose ceftriaxone and azithromycin was prescribed, followed by cefixime for 1 week. Two weeks later his symptoms cleared.

Conclusion Reflecting on these cases a DGI diagnosis was attained following careful consideration of possible differentials and persistence in identifying *Neisseria gonorrhoeae*. Both diagnoses would have been missed if following current testing guidance which recommends penile-only sampling of heterosexual men.

C3 SYPHILITIC AORTITIS IDENTIFIED IN A PATIENT NEWLY DIAGNOSED WITH HIV – THE EMERGING TIP OF AN ONCOMING ICEBERG?

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10.1136/sextrans-2015-052126.36

Background A 38 year old man presented for HIV testing following his male partner's diagnosis. Examination revealed systolic and decrescendo diastolic heart murmurs, palpable thrill, bounding pulses, and positive Corrigan's sign. He had not tested previously for HIV or syphilis and had been in a monogamous relationship for 8 years. We describe this man who was asymptomatic – from both HIV and aortic valve disease – with incidental diagnosis of severe syphilitic aortitis following partner notification for HIV.

Results HIV antibody test was positive with baseline viral load 239505 copies/ml and CD4 count 103 cell/μL (8%). Syphilis serology was positive with rapid plasma reagin (RPR) 1:4. CXR was unremarkable. ECG was consistent with left ventricular hypertrophy with strain. Echo revealed severe mixed aortic valve disease, left ventricular hypertrophy, good LV systolic function and normal aortic arch appearance. He commenced prednisolone 60 mg OD for 5d, 72 hr before starting three weekly doses of 2.4 MU benzathine penicillin. He was admitted for 48 hr for cardiac monitoring at the start of treatment – which proceeded with no complication. Multidisciplinary involvement with GU physicians, cardiologists and cardiothoracic surgeons was instigated from the start with aortic valve ± root replacement planned imminently.

Discussion Resurgence of syphilis in the UK was reported in the late 1990s with an ongoing epidemic since, mainly involving MSM. Cardiovascular syphilis typically occurs 15–30 years following primary infection with *Treponema pallidum*, with complications in 10% of cases. Could this man be amongst the first cases to develop tertiary syphilis in this latest epidemic?

C4 A COMPLICATED CASE OF CANDIDA

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10.1136/sextrans-2015-052126.37

Background Vulvovaginal candidiasis (VVC) is a common condition caused by *Candida albicans* in 80–92%. *Candida robusta* is rarely identified in humans and has only been reported as a cause of VVC in pregnant women. We present a case of chronic *Candida robusta* VVC.

Case A 25 year-old, on Cerazette, presented to her GP with discharge and vulval itching; treatment with clotimazole was effective but symptoms recurred. In clinic, one month later, a clinical and microscopic diagnosis of VVC was made, she was treated with fluconazole plus econazole pessary and cream. HIV, syphillis, gonorrhoea and chlamydia were negative.

Despite initial improvement she represented with recurrent symptoms, microscopy and culture again confirmed Candida species. Following a fourth presentation oral fluconazole 150 mg every 72 h x 3 followed by a weekly dose for three months was commenced. She was asymptomatic during this time but relapsed on discontinuation. Microscopy again confirmed spores and on speciation Candida robusta sensitive to fluconazole was isolated. A second 3-month fluconazole course was given. She had now developed provoked vulvodynia. Low-grade symptoms persisted and Candida robusta was again cultured, now resistant to fluconazole. A one-week course of oral voriconazole was given. Follow-up microscopy was negative but her vulvodynia had worsened. Treatment with amitriptyline was commenced and on review two months later culture remained negative and her vulvodynia had improved.

Discussion We report a case of chronic Candida robusta VVC in a non-pregnant immunocompetant woman, which acquired fluconazole resistance and precipitated vulvodynia. Speciation and sensitivity testing are important in women with recurrent symptoms.

C5 A CASE OF REPEATED RHABDOMYOLYSIS ASSOCIATED WITH PEPSE: AN UNCOMMON SIDE EFFECT OF RALTEGRAVIR

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10.1136/sextrans-2015-052126.38

Background/introduction The first line regime for PEPSE recently changed to Truvada/Raltegravir. We report on a case of rhabdomyolysis associated with Raltegravir.

Case A 25 year old MSM requested PEPSE in February 2013. Commencing Truvada/Kaletra, he switched to Truvada/Darunavir/Ritonavir due to arthralgia. He further received Truvada/Darunavir/Ritonavir 4 months later for another PEPSE request.

A third PEPSE episode was initiated in September 2014 commencing Truvada/Raltegravir. Baseline investigations showed an eGFR 75 ml/min/1.73 m^2. Two weeks later the patient was complaining of severe myalgia/lethargy. Also he noticed his urine colour change to brown. Repeat investigations were: creatinine 121 umol/L, eGFR 62 ml/min/1.73 m^2, Creatine Kinase (CK) 1392 iu/L, urine protein/creatinine (uPCR) 2.9 mg/mmol. On urgent review he was admitted for IV rehydration and cessation of PEPSE having developed an acute kidney injury and rhabdomyolysis. His CK fell following fluid replacement.

In November our patient was seen again having self-initiated PEP following a needle-stick injury from a used needle. He had taken 1 Truvada/Raltegravir from left over medication. However he had recurring myalgia and lethargy. His repeat CK was 2625 iu/L. The regime was immediately stopped, however his muscle pains and weakness continued for 3 weeks with a slow decline in his CK.