Abstracts

antibodies develop in response to primary treponemal infection. Lack of development of such antibodies is known to occur amongst HIV positive patients but is unusual among HIV negative patients with no significant comorbidities.

Aim(s)/objectives To present a cluster of four cases of primary syphilis from our clinic with unexpected serological results.

Methods We describe four unusual cases of HIV-negative MSM, all of whom presented with penile lesions (three chancres and an atypical lesion). These cases were identified by clinicians between July 2014 and January 2015. Clinical and laboratory records were retrospectively interrogated. Clinical photographs will be used to illustrate these cases.

Results In all cases, patients with no history of previous syphilis returned positive results on one or more specific treponemal serological tests with persistently negative RPR. Three cases had recent negative syphilis screening at our clinic. Darkfield microscopy also failed to demonstrate *T. pallidum* in those with chancres. In all cases, treatment of presumed syphilis led to the resolution of the lesions.

Discussion/conclusion These cases demonstrate the ongoing difficulties with treponemal diagnostic test interpretation. There are reports in the literature that men over 35 may be more likely to return a false negative RPR result, but overall prevalence of false negative RPR in primary syphilis is uncertain. Over-reliance on serology may result in under diagnosis of syphilis even in HIV-negative MSM.

P45

RECALCITRANT *TRICHOMONAS VAGINALIS*; A CASE SERIES OF TREATMENT CHALLENGES AT TWO URBAN SITES

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10.1136/sextrans-2015-052126.89

Background/introduction *Trichomonas vaginalis* (TV) remains common in England, with 6475 cases reported in 2013.¹ BASHH guidelines² advocate first line TV treatment with metronidazole (2 g stat or 400 mg BD for five to seven days) or a single dose of tinidazole (2 g). Recalcitrant infections have been well documented and may be caused by inadequate therapy, reinfection or antibiotic resistance.³ In the US, up to 5% of isolates of TV demonstrate a degree of resistance.⁴ In the UK there

remains no facility to test for TV resistance, leading to multiple 'blind' treatment approaches. We wished to evaluate the prevalence and clinical management of recalcitrant TV in our services.

Methods Clinic databases were used to identify patients with recalcitrant TV attending two sexual health services over a two year period.

Results A total of 1046 cases of TV were seen across the two services in the study period. Four female patients (0.4%) with recalcitrant TV requiring three or more treatments were identified. The patients were aged between aged 25 and 47 years. Two were black British, one white British and one white European. All four patients failed to respond to at least two five day courses of metronidazole; they required between three and eleven different courses of treatment, as per the table below:

During the courses of treatment all four patients were microscopy and culture negative at least once. However, symptoms persisted and tests were subsequently positive on at least one other occasion, despite no risk of reinfection. Three patients subsequently responded to fourteen days of tinidazole and one required acetarsol treatment. Three were eventually cured of TV, taking between 3–7 months to achieve cure and 5 and 12 clinic visits; one was lost to follow up, presumed cured.

Discussion Recalcitrant TV is rare, but for patients affected, the absence of a UK facility to detect TV resistance means that individuals who fail to respond to first line therapy undergo multiple attempts at TV treatment, recurrent clinic visits and investigations.

P46

THE MANAGEMENT OF ABNORMAL LFTS IN AN HIV POSITIVE PREGNANT WOMAN

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10.1136/sextrans-2015-052126.90

Background Acutely deranged liver function tests (LFTs) in HIV positive pregnant women present challenges in balancing pregnancy-related conditions, antiretroviral (ARVs) toxicities and prevention of mother to child transmission (MTCT). A 34 year old HIV positive lady with a history of poor engagement in care, psychosis, cognitive impairment and recent nevirapine resistance

Abstract P45 Table 1 *Trichomonas vaginalis* case series

	Ethnicity	Age	First line treatment	Subsequent treatments	Time to clinical cure
1	White European	28	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days; TDZ 2 g OD 14 days	4 months (5 clinic visits)
2	Black British	47	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x3 (2 in community); MTZ 400 mg BD 5 day amoxicillin 500 mg TDS + clotrimazole pessary, TDZ 2 g STAT, TDZ 2 g BD 14 days	2 months-Lost to follow-up (5 clinic visits)
3	White British	29	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x 3; Amoxicillin 500 mg TDS 7 days+clotrimazole pessary + MTZ 400 mg BD 5 days, TDZ 2 g OD for 14 days	3 months (6 clinic visits)
4	Black British	25	MTZ 400 mg BD 5 days	MTZ 400 mg BD 5 days x 3; Amoxicillin 500 mg BD 7 days + MTZ 400 TDS 7 days; MTZ 1 g suppositories 7 days + amoxicillin 500 mg TDS 7 days, MTZ 2 g OD 5 days; TDZ 2 g OD for 14 days; MTZ 400 mg TDS +1 g PR 7 days; TDZ 2 g BD 14 days + TDZ 500 mg BD PV x2 courses; Acetarsol 500 mg pessaries ON 14 days	6 months (12 clinic visits)

was admitted at 26 weeks gestation under mental health legislation due to cognitive impairment and self-neglect.

Method She was commenced on darunavir/ritonavir 600 mg bd, truvada and raltegravir but three weeks later, at 29 weeks gestation, she developed rapidly progressive hepatic transaminitis. Abdominal ultrasound scan was normal and tests for viral hepatitis negative. Pre-eclampsia was excluded, leaving three working diagnoses: drug-induced hepatitis, obstetric cholestasis or acute fatty liver of pregnancy. ARVs were stopped but transaminases continued to rise (ALT 614 and AST 716 U/L). Clotting screen and platelet count remained normal but the patient began to complain of epigastric pain. HIV viral load had risen to 241 copies/ml. In view of deteriorating maternal health and the increasing risk of MTCT (HIV viral load expected to rise), the baby was delivered at 31 weeks' gestation by semi-elective caesarean after a course of antenatal steroids. The baby received antiviral prophylaxis in the form of abacavir, lamivudine and zidovudine; HIV RNA was undetectable at three months (MTCT extremely unlikely). Nine days after delivery the patient's LFTs normalised.

Conclusion Darunavir-induced hepatitis typically presents with increased AST and ALT. In this case, LFTs only started to improve following delivery of the baby, suggesting a pregnancy related cause.

P47 HIV SEROCONVERSION IN PREGNANCY RUNS AN INCREASED RISK OF MOTHER TO CHILD TRANSMISSION (MTCT)

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10.1136/sextrans-2015-052126.91

Background We present the case of a couple who attended our sexual health service – him with a Severe Primary Herpes episode and other indicators of immune compromise and her in her 41st week of pregnancy. Their last sexual contact was nine days previously. Urgent HIV testing was undertaken using a fourth generation test with the male partners' test being positive and the female partners' test being negative. Viral load testing was requested with a result anticipated in 24 h.

Method During the night his partner went into labour. We calculated the risk of MTCT in this unique situation as being approximately 1:4000 and advised the patient that this could be decreased to 1:10 000 with Nevirapine, Zidovudine and a delivery by caesarean section. The baby received triple drug antiviral therapy until a negative viral load was confirmed approximately 6 h after delivery. Due to the risk of seroconversion the mother decided not to breastfeed even with antiretroviral cover, although sterilisation of expressed breast milk was discussed. Management of serodiscordant couples during pregnancy with ongoing risk of transmission is not discussed in the BHIVA guidelines and there is little evidence/guidance to base decisions around breastfeeding and retesting on.

Conclusion We wonder if we had been able to get a viral load on the female sample more quickly, would it have prevented caesarean section or would concerns around risk of acquisition from the genital tract during vaginal delivery (should she be in the 'eclipse' phase of HIV) have still made us advise an operative delivery.

P48 MYCOBACTERIAL SPINDLE CELL PSEUDOTUMOUR IN A PATIENT WITH HIV

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10.1136/sextrans-2015-052126.92

Background/introduction Mycobacterial spindle cell pseudotumour is a rare, benign lesion caused by local proliferation of histiocytes in response to mycobacterial infection. It most commonly occurs with mycobacterium avium intracellulare. Most cases affect lymph nodes, skin and brain. We present a case occurring in the lung of a patient with HIV.

Methods A 38 year old Caucasian gentleman was admitted with 1 year history of weight loss, cough and diarrhoea. As a result of declining health and recent HIV diagnosis, he had returned to UK after living 8 years in Thailand. He had commenced anti-TB drugs 6 weeks previously; however no details were available regarding previous investigations. He was profoundly immunosuppressed, with CD4 count < 10 copies/mm³. CT chest showed widespread cavitating lesions throughout both lung fields. Cultures from sputum and bronchial washings grew mycobacterium avium intracellulare and clarithromycin was added. Antiretroviral treatment was started 2 weeks later. Biopsies from bone marrow and bowel showed no evidence of granuloma or malignancy. He suffered frequent episodes of hypercalcaemia. As a result of this, and lack of radiological response to mycobacterial treatment and ARV, CT guided lung biopsy was carried out. This showed mycobacterial spindle cell pseudotumour. Clinically he continued to improve, with immune recovery. Anti-mycobacterial treatment was to continue for 12 months.

Discussion/conclusion Mycobacterial spindle cell pseudotumour is a rare complication of mycobacterial infection. The majority of patients are immunocompromised, including those with advanced HIV. It may share some histological features with Kaposi Sarcoma, therefore correct identification is essential. Treatment depends on the mycobacterial species identified.

P49 TOXIC CARDIOMYOPATHY IN A STABLE HIV PATIENT WITH A HISTORY OF AMPHETAMINE MISUSE-A CASE REPORT

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10.1136/sextrans-2015-052126.93

Background/introduction Amphetamine (AM) use is associated with HIV infection among MSM. There are various toxic effects of AM, cardiotoxicity being one of them.

Aim(s)/objectives To present a case of report of cardiomyopathy secondary to AM misuse in a patient with well-controlled HIV.

Case report A 51 year old HIV positive MSM was admitted to hospital with dyspnoea, orthopnoea and decreased exercise tolerance. He was HIV positive since 1990 and this is stable on ARVs. CD4 count pre-admission was 514 with undetectable viral load. He used 25–30 grams of AM per week over a period of 20 years and had multiple casual unprotected MSM partners. On admission, the patient was tachycardic and hypoxic. Chest X-Ray on admission showed cardiomegaly and bi-basal opacification. Echocardiogram demonstrated severe left and right