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.

**Abstract P45 Table 1 Trichomonas vaginalis case series**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>First line treatment</th>
<th>Subsequent treatments</th>
<th>Time to clinical cure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 White European</td>
<td>28</td>
<td>MTZ 400 mg BD 5 days</td>
<td>MTZ 400 mg BD 5 days; TDZ 2 g OD 14 days</td>
<td>4 months (5 clinic visits)</td>
</tr>
<tr>
<td>2 Black British</td>
<td>47</td>
<td>MTZ 400 mg BD 5 days</td>
<td>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</td>
<td>2 months-Lost to follow-up (5 clinic visits)</td>
</tr>
<tr>
<td>3 White British</td>
<td>29</td>
<td>MTZ 400 mg BD 5 days</td>
<td>MTZ 400 mg BD 5 days x3; Amoxicillin 500 mg BD 7 days+ clotrimazole pessary + MTZ 400 mg BD 5 days, TDZ 2 g OD 14 days</td>
<td>3 months (6 clinic visits)</td>
</tr>
<tr>
<td>4 Black British</td>
<td>25</td>
<td>MTZ 400 mg BD 5 days</td>
<td>MTZ 400 mg BD 5 days x3; Amoxicillin 500 mg BD 7 days + metronidazole 7 days; MTZ 2 g OD 14 days; TDZ 2 g BD 14 days</td>
<td>6 months (12 clinic visits)</td>
</tr>
</tbody>
</table>

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.

**Abstract P46 The management of abnormal LFTs in an HIV positive pregnant woman**

1 Gillian Fraser*, 1 Andrew Winter, 2 Roch Cantwell, 3 Helen Mactier, 3 Elizabeth Ellis, 1 Brownlee Centre, Garthwaite General Hospital, NHS GG&G, Glasgow, UK; 2 Perinatal Mental Health Service, Lendalhead Hospital, NHS GG&G, Glasgow, UK; 3 Princess Royal Maternity Hospital, NHS GG&G, Glasgow, UK

**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...
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 transaminisitis. 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)**

Rebecca Acquah*, Fiona Fargie, Andrew Winter. Sandyford Sexual Health Service, NHS Greater Glasgow and Clyde, Glasgow, UK

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 partner’s test being positive and the female partner’s 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**

Eoin Walker*, Emma McCarty, Claire Donnelly, Carol Emerson, Say Quah. Royal Victoria Hospital, Belfast, UK

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**

Durba Raha*, Imali Fernando. Chalmers Sexual Health Centre, Edinburgh, USA

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