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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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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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/mm^3. 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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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

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