were not using hormonal contraception. We used Poisson mixed effects models to determine if genital HSV DNA detection or lesion frequency differed throughout the menstrual cycle, categorised into four seven-day phases based on most proximate first day of menstrual bleeding: early and late for each of follicular and luteal.

**Results** In 189 women aged 19–46 (median age 33) who collected 9307 genital swabs, HSV was detected on 1822 days (20%). The rate of shedding was 21% during the early follicular phase versus 18% during late luteal (RR=1.2, 95% CI 1.0–1.4, p=0.04), 21% during late follicular (RR=1.2 relative to late luteal, 95% CI 1.0–1.5, p=0.06), and 19% during early luteal (RR 1.1 relative to late luteal, 95% CI 0.9–1.3, p=0.53). In sensitivity analyses reducing misclassification of phase by excluding samples >10 days from day 1 of menses, these observations were strengthened. The pattern was similar for genital lesions, present on 13% of days during the follicular phase and 11% during the luteal phase.

**Conclusion** In women with established HSV infection, genital HSV-2 shedding and lesions were slightly more common during the early follicular phase of the menstrual cycle than in the luteal phase. These cyclic variations may be related to changes in oestrogen and progesterone affecting vaginal immunity.

**P2.15 PERSISTENCE OF CYSTOISOSPORA BELLI IN HIV PATIENTS: DRUG FAILURE, RESISTANCE OF THE PARASITE OR INCOMPLETE IMMUNE RESTORATION?**

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**Introduction:** Cystoisospora bellí infection is one of the most important causes of watery diarrhoea in patients with HIV and causes high rates of morbidity and mortality. The introduction of highly active antiretroviral therapy (HAART) in recent years has improved the ability of immune response and decreased viral load.

**Methods** A prospective study was performed among HIV patients admitted to hospital of Lambayeque. Herein we describe seven clinical cases of diarrhoea caused by *C. bellí* infection in HIV patients, who showed different evolution and response to treatment.

**Results** Five were males, with a mean age of 32 years and chronic diarrhoea. Four patients had recurrent diarrhoea despite receiving secondary prophylaxis with cotrimoxazole and good viral and immunological response to HAART in addition to specific treatment. While others were not receiving HAART and prophylaxis, but responded well to treatment.

**Conclusion:** *C. bellí* is an important cause of diarrhoea in HIV patients on HAART and prophylaxis. In this study, 7 cases of patients with HIV infection and diarrhoea caused by *C. bellí* are presented. Three of those were newly diagnosed, so they did not receive HAART and secondary cotrimoxazole prophylaxis and their CD4+ levels were below 200/µL. However, they responded favourably to *C. bellí* treatment, with no recurrences. Meanwhile, the other four patients were receiving HAART, secondary prophylaxis and had evidence of immune restoration (>200 CD4+/µL), but the standard treatment failed to eradicate the parasite. This clinical contradiction has been reported previously with some particularities.

We suggest that persistent infection may be due to drug failure by intrinsic or extrinsic to the parasite causes, or to defects in restoration of the intestinal immune system, or both.