

243. Watch Out! Syphilis Is Back – Case Series of Four Cases of Ocular syphilis
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Background. Syphilis is an ulcerative sexually transmitted genital infection caused by *Treponema pallidum*, which is a member of the order *Spirochaetales*, family *Spirochaetaceae*, and genus *Treponema*. The incidence rate of Syphilis has been steadily rising since 2000; from 2.1 cases per 100,000 population to up to 7.5 cases per 100,000 population in 2014–2015 (the highest rate since 1994). In the state of West Virginia, we have witnessed an increase in the number of cases from 0.5 cases per 100,000 population in 2011, to 5.9 cases per 100,000 population in 2015. Systemic symptoms can include cardiovascular and neurological manifestations. We report to your attention four cases of syphilis mainly with neurological and ocular manifestations.

Methods. We report a series of four cases of neurosyphilis we encountered between 2013 and 2016. Main presentation of all four cases was ocular; primarily redness and photophobia. Diagnosis was confirmed by standard ophthalmological examination with positive initial rapid plasma regain titers (RPR) and fluorescent treponemal antibody absorption testing (FTA-ABS). The cerebrospinal fluid venereal disease research laboratory test (CSF-VDRL) was positive in two of the four cases (in which lumbar puncture was performed). Two of the four cases suffered from an overt immunodeficiency (HIV and laryngeal cancer on chemotherapy) and subjects of all four cases confessed to high-risk sexual behaviors. All four cases were managed with continuous infusions of Penicillin G potassium 24 million International Units for 14 days with variable response.

Results. Response to treatment was variable in that initial complete resolution was achieved in one patient (Case #3), another (Case #1) was retreated in 6 months due to rising RPR titers on follow-up with subsequent improvement. Two patients were lost to follow-up (Cases #2 and #4).

Conclusion. Sir William Osler reportedly said: “He who knows syphilis knows medicine”. The steady rise in the incidence of Syphilis warrants that health care providers consider such a diagnosis in the evaluation of suggestive neurological and ocular manifestations in predisposed patients. We also stress on the importance of follow-up to detect failure of initial treatment.

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244. Similar Sexually Transmitted Infections Prevalence Despite Lower HIV Prevalence Among Transgender Women Compared with Men Who Have Sex With Men in Thai Community-Based Test and Treat Cohort

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Background. Men who have sex with men (MSM) and transgender women (TG) are at increased risk for sexually transmitted infections (STIs). To understand potential different characteristics, we assessed gender-specific, demographic data, behavioral risks and prevalence of STIs.

Methods. Thai MSM and TG aged ≥18 years from six community-based organizations in Thailand were enrolled into the Test and Treat cohort during 2015–2016. Baseline demographic and behavior risk assessment and HIV/STIs testing were done. Blood for syphilis serology and pharyngeal and anal swab, and urine for gonorrhea and chlamydia nucleic acid amplification testing were collected. Logistic regression was used to determine factors associated with gender-specific STIs prevalence.

Results. From 1862 MSM and 787 TG enrolled, 874 (33%) had STI and 402 (15.2%) were HIV-positive. Compared with MSM, more TG were single (79.7% vs. 71.6%), had lower education (23.6% vs. 40% with diploma or higher), had lower income (35.7% vs. 42.6% gained >288 USD/month), had first sex at young age (20.1% vs. 12.8% at <15 years old), and reported >3 sexual partners in the past 6 months (32.9% vs. 24.6%) (all $P < 0.001$). The overall STIs prevalence was similar between both genders (31.5% vs. 33.6%, $P = 0.29$), but TG had lower HIV prevalence (8.9% vs. 17.8%, $P < 0.001$). TG had higher prevalence of pharyngeal and anal chlamydia (5.5% vs. 2.9%, $P = 0.001$ and 19.5% vs. 15.1%, $P = 0.007$, respectively), while syphilis prevalence was higher in MSM (9.9% vs. 3.6%, $P < 0.001$). Among HIV-positive

participants, MSM had higher prevalence of HIV and syphilis coinfection (26.2% vs. 8.6%, $P = 0.001$). STIs prevalence among TG was associated with HIV-positive status (adjusted odd ratio [aOR] 2.74; 95% CI 1.52–4.95, $P = 0.001$), having multiple sexual partners or refused to answer (aOR 2.36; 95% CI 1.31–4.24, $P = 0.004$ and 2.33; 95% CI 1.24–4.37, $P = 0.009$, respectively) and unprotected sexual intercourse (aOR 1.66; 95% CI 1.02–2.69, $P = 0.041$).

Conclusion. Almost one-third of TG enrolled into the Test and Treat cohort had STI. TG had lower HIV prevalence but similar STIs prevalence compared with MSM, despite practicing riskier sexual behaviors. Our findings signified the importance of studying TG sexual networks in Thailand to better strategize sexual health programs.

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245. How Many Patients Who Present to North Central Bronx Hospital with a Sexually Transmitted Disease (Chlamydia, Gonorrhea) Are Tested for HIV?
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Background. To determine whether an individual got infected with either Chlamydia trachomatis, N gonorrhea, or both infected, the HIV test was ordered or not.

Methods. Systematic review and data synthesis of STD and HIV testing results through Quardamed within the 1 month period of November, 2015. Percentage of patients with and without a STD (either Chlamydia trachomatis, N gonorrhea, or both infected) who had HIV test done.

Results. 804 patients were tested for gonorrhea or chlamydia by GC probe during November 2015. Thirty-three of 804 (4.1%) individuals were infected with Chlamydia trachomatis. Of those 20 were tested for HIV by rapid oral test. Six of 804 (0.7%) participants who were infected with N gonorrhea had five HIV rapid test done. Two of 804 (0.3%) participants were infected with both diseases and one patient was tested for HIV. Most patients with a confirmed STD were diagnosed in ED (43.4%) followed by OB/GYN (37.3%). Seventy-two percent of patients who were either infected with chlamydia, gonorrhea or both were tested for HIV. In the ED, 48% had an HIV test vs. 80% in OB/GYN (including family planning).

Conclusion. The majority of patients were tested for HIV. More patients were tested in OB/GYN compared with the ED likely because an HIV counselor is readily available during clinic hours. Increase in education and training of health care providers and nurses to become more comfortable in testing patients for HIV may increase the number HIV testing when patients present with STDs.

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246. Lymphogranuloma Venereum: a Croatian Case Report of a Patient with Proctitis and Concurrent Cervical Lymphadenitis

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Background. *Lymphogranuloma venereum* (LGV) can present with genital ulcers, proctitis, or femoral/inguinal lymphadenopathy with or without constitutional symptoms. There have been reports on the infection characterized by supraclavicular or cervical lymphadenopathy, although there is no published data on the detection of *Chlamydia trachomatis* (CT) in the affected lymph node.

Methods. We report a patient with pharyngitis, proctitis and cervical lymphadenitis, in whom LGV specific DNA was detected by polymerase chain reaction (PCR) in both the rectal swab and cervical lymph node fine needle aspirate.

Results. A 48-year-old Croatian HIV-positive male patient attended our outpatient HIV clinic complaining of a 10-day perianal pain, bloody rectal discharge with normal stool consistency and painful and enlarged cervical lymph node. On the first day he had fever, which subsided on the following day. Clinical examination demonstrated exudate on the right tonsil, painful, and enlarged right cervical lymph node (5 × 2 cm, Figure 1), perianal pain on palpation and rectal purulent discharge. During the preceding 10-year period, the patient was taking his antiretroviral therapy regularly and had an undetectable HIV RNA by PCR. We started treatment with ceftriaxone and doxycycline. The fine needle aspirate of the affected lymph node showed a pyogranulomatous inflammation. Indirect immunofluorescence assay on CT antibodies detected positive titers in IgG (>512) and IgA (256) classes. LGV-specific DNA was detected in both the rectal swab and the cervical lymph node fine needle aspirate. Ceftriaxone was discontinued after 5 days and doxycycline therapy was continued for a total of 6 weeks because of the persistence of the cervical lymphadenopathy. The patient came to a full recovery.

Conclusion. We found six published case reports on LGV with associated cervical lymphadenopathy in which the infection with CT was established by serologic testing and/or by nucleic acid amplification tests of the pharyngeal and/or rectal swabs. Some of the mentioned reports demonstrated granulomatous inflammation present in the affected cervical lymph node, as was evidenced in our patient. To our knowledge, this is the first case report of a patient with CT infection in whom LGV-specific DNA was detected in the cervical lymph node.

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