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Lymphogranuloma venereum proctocolitis: a silent endemic disease in men who have sex with men in industrialised countries

R. Martin-Iguacel · J. M. Llibre · H. Nielsen · E. Heras ·
L. Matas · R. Lugo · B. Clotet · G. Sirera

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Abstract Lymphogranuloma venereum (LGV) is a sexually transmitted disease (STD) caused by serovars L1–L3 of *Chlamydia trachomatis*. Rare in the western world prior to 2003, different outbreaks or clusters of LGV have been reported in Europe, North America and Australia among men who have sex with men (MSM) over the past few years. The majority were HIV infected MSM with high-risk sexual behaviour and a high rate of concomitant STD, including hepatitis C. Most of them presented with a proctitis syndrome and only a few with the classical bubonic form. A previously non-described serovar, L2b, has been identified as the main causative agent of the epidemic. A delay in diagnosis has been the rule because of the misleading symptomatology of LGV proctitis, the unfamiliarity of the disease to physicians, and the lack of a routine diagnostic test for LGV serovars. It is crucial to

increase the awareness of the disease among physicians for prompt diagnosis and treatment, to avoid complications, and to stop ongoing transmission. It has additional public health implications since LGV may facilitate the transmission and acquisition of HIV and other STD.

Introduction

Lymphogranuloma venereum (LGV) is a systemic sexually transmitted disease (STD) caused by serovars L1, L2 and L3 of the obligate intracellular bacterium *Chlamydia trachomatis*. *C. trachomatis* is classified into 15 serovars based on immunogenic epitope analysis of the major outer membrane protein. Serovars A, B, Ba and C are associated with ocular trachoma and strains D–K with genital tract disease and with inclusion conjunctivitis, and represent the most frequent STD in industrialised countries. Only serovars L1, L2 and L3 cause LGV, probably due to their tropism for the lymphatic system, in contrast to serovars A–K, which affect mucocutaneous tissue. The L2 serovar can be further classified into L2, L', L2a and L2b, and the recently described L2c–L2g according to amino acid differences [1, 2].

Endemic in Africa, the Caribbean and many parts of Asia, prior to 2003 LGV was considered rare in industrialised countries and the sporadic cases seen were deemed to be imported from endemic areas. In 2003 a cluster of LGV with a new strain, L2b, was detected in Rotterdam, the Netherlands, among men who have sex with men (MSM) presenting mainly as proctitis [3]. Since then many countries all across Europe, North America and Australia have reported clusters of cases in sexual networks of MSM with a total of over 1,600 cases of proctitis reported so far [1, 2, 4–19].

R. Martin-Iguacel (✉) · H. Nielsen
Department of Infectious Diseases,
Aalborg Hospital, Aarhus University Hospital,
Hobrovej 18, P. O. Box 365, DK9100 Aalborg, Denmark
e-mail: raquel@bisaurin.org

R. Martin-Iguacel · J. M. Llibre · E. Heras · B. Clotet · G. Sirera
Lluita contra la SIDA Foundation,
University Hospital Germans Trias I Pujol,
Barcelona, Spain

L. Matas
Microbiology, University Hospital Germans Trias I Pujol,
Barcelona, Spain

R. Lugo
CEEISCAT, University Hospital Germans Trias I Pujol,
Barcelona, Spain

B. Clotet
Irsi-Caixa Foundation,
Barcelona, Spain

The majority of patients were HIV-infected with high rates of promiscuity and high-risk sexual behaviour, often involving international sexual networks, which correlates with the high rate of concomitant STD observed.

The atypical clinical presentation, the unawareness of physicians and patients with regard to the disease, and the lack of a routine diagnostic test for LGV serovars of *C. trachomatis* have conditioned a delay in the diagnosis and even misdiagnosis.

The untreated disease is associated with significant sequelae with chronic inflammation of the lymphatic vessels, progressive lymphoedema and sclerosing fibrosis leading to fistula formation and strictures and disfiguring conditions such as genital elephantiasis and esthiomene [20].

The current resurgence of LGV represents furthermore a significant public health problem as the ulcerative nature of LGV may facilitate both transmission and acquisition of HIV infection and other STD as well as other blood-borne diseases like hepatitis C [21].

It is therefore critical to increase the awareness of the re-emergence of this disease among health care professionals in industrialised countries for prompt diagnosis and appropriate treatment. It is important to highlight that specific diagnostic tests not routinely used are required to allow the diagnosis of LGV infections.

This review addresses the characteristics of the present recurrence of LGV proctocolitis in MSM in high-income, non-tropical settings.

Materials and methods

This review used a systematic search in the literature using PubMed. The incorporating criteria were “*Chlamydia trachomatis*”, “*Lymphogranuloma venereum*”, “*homosexual male*”, “*men who have sex with men*” and “*proctitis*”. The search was restricted to the period 1990–2009 and only those series reporting more than 5 patients were included in the present review. A total of 25 studies were identified.

Epidemiology

Lymphogranuloma venereum was endemic in Europe and the US in the pre-antibiotic era, but thereafter only sporadic cases were seen in the western world, and all were considered to be imported [22, 23]. However, in the 1980s some clusters of LGV in MSM presenting as proctitis were reported in industrialised, non-tropical areas [24, 25]. The estimates of incidence are difficult to ascertain, as LGV was not a mandatory reportable disease in most countries. It is still currently endemic in parts of Africa, South East Asia, South America and the Caribbean.

In February 2003 the first case of LGV proctitis in Europe was detected in a recently infected HIV-positive bisexual white man who presented with a painful perianal ulcer, bilateral inguinal lymphadenitis and general malaise in Rotterdam, the Netherlands (NL) [26]. Subsequently, a cluster of 13 MSM with LGV serovar L2 was detected through contact tracing [3], most of whom were HIV-positive. They presented with a median duration of 3 months of unspecific intestinal symptoms and 46% had another concomitant STD [1–10]. Several outbreaks in MSM have so far been reported in Western Europe, Australia and the USA, clustering in large cities [2, 4–15, 27–32].

A total of 232 cases of LGV proctitis had been recorded in the NL by March 2007 [15]. Previously, the NL had an incidence of LGV of fewer than 5 cases per year. In the UK a total of 492 cases had been recorded by April 2007, in France 244 cases by December 2005, in Germany 78 by November 2005 and in Sweden 20 cases by December 2007, of which 15 were detected in 2007 [4, 7, 16, 33]. In Canada there were 88 cases by September 2007 [28]. The first case of LGV in Barcelona was reported in an MSM in 2005 and as of April 2009 a total of 42 confirmed cases had been reported in Catalonia, an autonomous community in the north-east corner of the Iberian Peninsula with a population of around 7 million (Fig. 1).

In all these countries LGV proctitis has been described nearly exclusively in MSM most of whom were HIV-infected, but typically not immunosuppressed, and some had seroconverted to HIV at around the time of the LGV diagnosis [3, 6, 33]. The epidemic might be expanding beyond the initial core group of high-risk MSM [1, 34], even though the detection of LGV in the general population has not been confirmed in other studies [9, 35, 36]. The majority reported high-risk sexual behaviour including unprotected anal intercourse, fisting, sharing sex toys, often connected to the sex party scene and involving international sexual networks [3]. In a cross-sectional study the use of enemas was found to be associated with a higher risk of LGV proctitis, probably because such a procedure leads to mucosal damage before receptive anal intercourse favouring the transmission of the disease [37].

Contact tracing was difficult as most cases reported multiple, mainly anonymous sexual contacts.

The HIV-1 infection has been identified as the strongest risk factor for anorectal LGV [3, 38]. MSM have not been confirmed to be a reservoir of LGV and the high rate of HIV co-infection probably reflects the confounding effect of HIV as a surrogate marker of high-risk behaviour; nevertheless, a potential effect of HIV infection increasing the susceptibility to infection or facilitating the expression of the disease cannot be ruled out [2, 39–41].

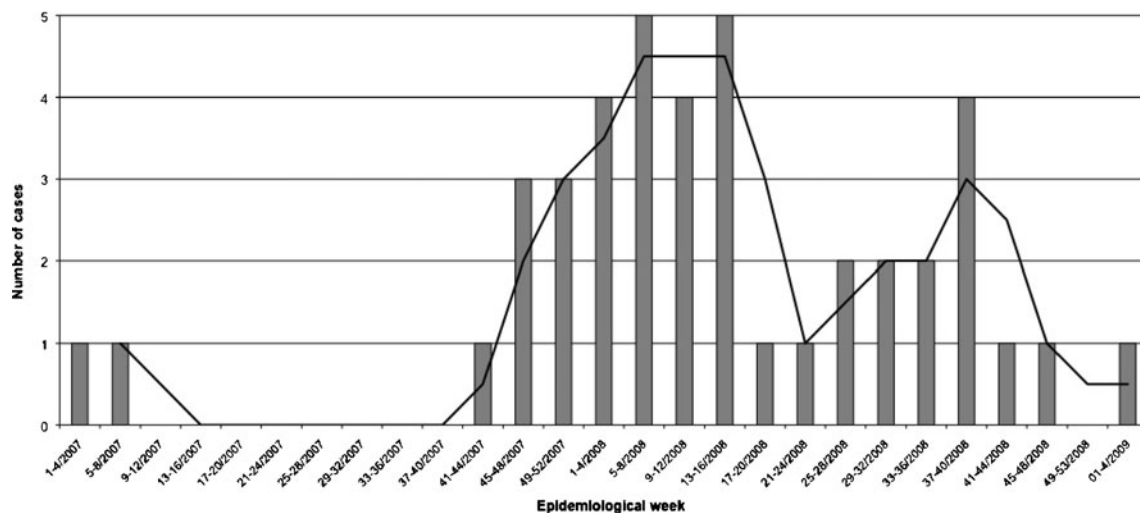


Fig. 1 Distribution of confirmed cases of lymphogranuloma venereum (LGV) by date of consultation, Catalonia (Spain), January 2007 to April 2009 (Source: CEEISCAT)

Since the introduction of highly active anti-retroviral therapy an increase in unprotected sexual practices has been observed worldwide among both HIV-positive and -negative MSM, which could have contributed to facilitating the spread of LGV in this core group. During the 1980s the Bahamas registered a sequential epidemic of crack cocaine use, genital ulcer-inguinal adenopathy disease (including bubonic LGV) and HIV infection in heterosexuals related to unsafe sexual behaviours [42].

It seems unlikely that LGV constitutes an opportunistic infection involving immunosuppressed HIV-infected patients, and studies have failed to detect a significant asymptomatic reservoir in the general population [9, 35, 36].

On the other hand, the ulcerative nature of LGV could enhance transmission and acquisition of HIV and other STD, as well as other blood-borne diseases like hepatitis C as indicated by the high co-prevalence of STD observed in these patients. Although hepatitis C is not usually considered a STD it has been consistently reported to be sexually transmitted among MSM, especially with high-risk sexual practices that lead to mucosal damage [21].

Almost all patients presented with long-lasting gastrointestinal symptoms and were initially misdiagnosed, which increased the risk of transmission. In some series there was a significant group with no or few symptoms, which could suggest that the number of cases reported might underestimate the real disease occurrence [37, 38].

A previously non-described L2b *Chlamydia* variant has been identified as the main causative agent [11, 27, 30, 43, 44]. Nevertheless, this variant seems to have been circulating in the NL since 2000 (no earlier samples were available) and has also been detected retrospectively in rectal samples from symptomatic MSM collected from 1979 to 1985 in San Francisco (LGV represented 13% of

the collected samples and 67.3% of the *C. trachomatis*-positive samples) [45]. This fact could support the hypothesis proposed by some authors of the existence of an ongoing unrecognised endemic disease among MSM for at least 20 years rather than a new outbreak [45, 46]. However, other countries have not confirmed the retrospective detection of undiagnosed cases in stored samples [8, 39, 47].

The existence of an unrecognised endemic disease could also be supported by the fact that before 2003 no systematic surveillance of LGV was available and that the diagnostic tests necessary to find LGV serovars of *C. trachomatis* were not routinely available, and anal swabs positive for *Chlamydia* were recorded as *Chlamydia proctitis* with no additional testing for LGV being performed. On the other hand, there are some characteristics suggesting an ongoing outbreak like a sudden increase in the number of cases potentially linked and the presence of geographical clustering. The increase in high-risk sexual practices, such as serosorting, among HIV-positive MSM after the introduction of highly active anti-retroviral therapy (HAART) could have contributed to the spread of the disease in the last years in this specific group, as observed for other STD such as syphilis and gonorrhea [48]. A selection bias (testing only HIV-infected patients and HIV-infected persons being more aware) cannot be excluded [9]. Further investigations are needed to shed light on this issue.

Clinical syndrome

Lymphogranuloma venereum is caused by *Chlamydia trachomatis* serovars L1–L3. Serovars B and D–K are responsible for the syndromes of non-gonococcal urethritis

and cervicitis and can also cause a mild inflammation of the rectal mucosa. It is an invasive disease and has tropism for the lymphatic system, causing severe inflammation, often with systemic implication in contrast to serovars A–K, which are associated with mild or asymptomatic systemic implications. LGV can be transmitted through vaginal, anal or oral sexual contact. The clinical characteristics depend on the site of inoculation.

The classical description of LGV consists of a primary lesion at the site of inoculation after an incubation period of 3–30 days involving a small, painless genital papula, which may ulcerate, heal spontaneously and leaving no scarring. This lesion frequently passes unnoticed. The initial infection can also be intraurethral, producing an asymptomatic urethritis, cervical, producing cervicitis, or in the rectum, producing proctitis. It was well known that LGV serovars were associated with more severe forms of proctitis, especially seen in the collective of MSM [24, 25], but this is probably more common than previously presumed.

This primary stage is followed after days to weeks by a secondary stage characterised by lymphatic involvement of those lymph nodes that drain the area of the primary lesion. In the classical form tender unilateral or bilateral inguinal and/or femoral (“groove” sign) adenopathies appear. When the primary infection occurs in the rectum the deep iliac lymph nodes are affected, but remain unnoticed. This can also be observed in women due to the drainage of the cervical or upper vaginal area to the perirectal lymph nodes. The lymph nodes become inflamed and painful and may coalesce to form a “bubo” or abscesses that may rupture spontaneously with the development of fistulas or sinus tracts. This stage may be associated with systemic features such as malaise, fever and headaches.

If untreated, a proportion of patients will progress to a chronic granulomatous inflammatory process (tertiary stage) with lymphatic obstruction leading to fistula formation and strictures and disfiguring conditions such as genital elephantiasis and esthiomene (Greek, “eating away”) which refers to hypertrophic enlargement with ulceration of the external genitalia.

In the present outbreak of LGV among MSM the majority of patients were HIV-positive with preserved CD4 cell counts. The role of the CD4 cell count in modulating the clinical picture of LGV proctocolitis, as occurs with almost all opportunistic infections associated with HIV, is yet to be elucidated [37]. In a retrospective study no differences in the clinical picture of proctitis investigated by proctoscopy were noted among HIV-positive patients who did or did not receive HAART [38]. However, more than the use of HAART, it would be interesting to examine the clinical presentation stratified by the CD4 count.

The immune restoration inflammatory syndrome (IRIS) seen with many opportunistic infections after the initiation of HAART seems unlikely to modulate the clinical presentation of LGV proctocolitis, since most patients had been on anti-retroviral therapy (ART) for several years before the LGV diagnosis and no signs of IRIS were registered [37, 38].

High rates of co-infection with other STD and hepatitis C have been observed [3, 6, 21]. Tables 1 and 2 summarise the main clinical characteristics of different series reported so far, where wide variations in clinical symptoms can be observed. They presented typically with a rectal syndrome (>90%) with moderate to severe ulcerative proctitis or proctocolitis with mucopurulent discharge, rectal pain, bloody rectal discharge, constipation and tenesmus. Systemic symptoms like fever and malaise and weight loss were relatively common. Paradoxically, simultaneous penile lesions and/or inguinofemoral lymphadenopathy have been reported rarely [49]. Despite the fact that most patients had reported unprotected insertive and receptive anal sexual intercourse, only few cases of urethritis due to LGV serovars have been reported in the present outbreak [35, 50]. The reason why the bubonic form or the urethral infection is not more commonly reported remains unclear. Some reports have suggested transmission through sex toys, but further research will be required to reveal the exact mode of transmission.

Some patients were pauci-symptomatic or asymptomatic, up to 40% in the Dutch series, but other studies have failed to demonstrate a significant reservoir of asymptomatic or urethral infection in MSM or in the general population [2, 39, 40, 50, 51]. On the other hand, the absence of the classical clinical features of LGV have also conditioned a delay in the diagnosis and treatment in the current outbreak as evidenced by the large number of cases diagnosed retrospectively, allowing ongoing transmission [5, 8, 11, 43, 46].

The endoscopic findings included mucopurulent exudate with a hyperaemic and friable mucosa, easily bleeding, with multiple ulcers and erosions being replaced by granulomatous tissue and tumorous inflammatory masses. However, in some reports up to 40% of men with LGV proctitis showed no anoscopic abnormalities [37, 38]. Even these endoscopic findings are unspecific and the disease can be misdiagnosed. The pathology shows typically only non-specific inflammatory features with an intense chronic inflammatory process. It is crucial to remember that the histology is non-specific and can be easily misinterpreted, even by trained pathologists [3].

Clinical proctitis is a common problem in MSM and clinicians should suspect LGV in MSM who present with colorectal gastrointestinal symptoms. Diagnosis may be hampered because rectal LGV may clinically and histologically mimic other conditions such as inflammatory bowel

Table 1 Main characteristics of lymphogranuloma venereum cases in men who have sex with men (MSM) reported between 1990 and 2009

| Country | Period of study | Cases (number) | Median age (year) | HIV (%) | STD ^g (%) | Hep C (%) | HAART (%) | Proctitis ^h (%) | Asymp ^j (%) | Proc ^l (%) |
|--------------------------|-----------------|-----------------|-------------------|-----------------|----------------------|-----------|-----------|----------------------------|------------------------|-----------------------|
| The Netherlands [38] | 2002–2003 | 87 | 37.6 | 60 | 21 | | 54 | | | 47 |
| The Netherlands [43] | 2002–2003 | 45 | 35.8 | 69 | | | | | | |
| The Netherlands [3] | 2004 | 13 | 39 | 85 | 46 | 8 | 36 | 92.3 | | 100 |
| France [11] | 2002–2005 | 244 | 39 | 85 ^e | | | | Most patients | | |
| UK [5] | 2004 | 24 | 40 | 90 | 42 | 21 | | 94.7 | | |
| The Netherlands [14] | 2004–2005 | 114 | 40 | 67 | Frequent | 10 | | 91 | 18 | |
| Belgium [10] | 2004–2005 | 13 | | 92 | | | | 100 | | |
| Switzerland [8] | 1999–2005 | 10 | | 70 | | | | 100 | | |
| The Netherlands [37] | 2004–2006 | 32 | 39.6 | 78 | 19 | 13 | | | 40 ^k | 60 |
| UK [6] | 2004–2006 | 327 | 38 | 76 | 39 | 19 | 45 | 96 | 13 | |
| UK [7] | 2004–2007 | 492 | 40 | 74 | 48 | 14 | | 90–77 ^l | 5–18 ^l | |
| The Netherlands [15] | 2006–2007 | 57 | 45 | 77 | Frequent | | | Most patients | | |
| Spain ^a | 2007–2009 | 42 | 39.4 | 91 | 50 | | | Most patients | | |
| Australia [29] | 2005–2008 | 11 | 47 | 82 | | | | 81.8 | | |
| Canada [28] | 2001–2007 | 88 | 37.5 | 78 | Frequent | 6 | | | | |
| Sweden [16] | 2007 | 15 | 38 | 73 | 40 | | 33 | 80 | 6.6 | |
| Germany [4] | 2004–2005 | 78 | 39 | 96 ^f | | | | 75 | | |
| Italy [13] | 2006–2007 | 13 | | 62 | 38 | | 46 | 77 | | |
| France [12] | 2002–2004 | 22 | 39.2 | 57 | | | | 100 | | |
| Austria [2] ^b | 2005–2006 | 15 | 41.3 | 85 | 53 | | 13 | 86.7 | | |
| France [33] | 2003–2004 | 38 ^c | 40 | 57 | 64 | | | 100 | | |
| Canada [27] | 2004–2005 | 22 ^d | 38 | 73 | | 25 | | 78 | | |
| Portugal [1] | 2007 | 8 | 36 | 25 | 38 | | | 12.5 | 75 | |

^a Data from CEEISCAT in Catalonia (Jordi Casabona, personal communication)^b Mean CD4 count 469 (±180.4) cells/mL. No specification of CD4 count was available in the other studies^c Complete surveillance data were available for 14 of the 38 patients^d Surveillance data were available for 19 of the 22 cases, though not complete for all cases^e HIV status was available for 96 patients, of which 82 were known to be HIV-positive^f HIV status was available for 52 patients, of which 50 were known to be HIV-positive^g Concomitant sexually transmitted disease (STD)^h Proctitis syndrome includes, unless otherwise stated, variable degrees of loose, bloody stools associated with the passage of mucus, cramping abdominal pain, rectal tenesmus and low-grade fever. Periods of constipation are also common^l Proctitis syndrome was present in 90% of the individuals in the period of 2004–2005 and in 77% in 2006–2007; asymptomatic patients accounted for 5% in 2004–2005 and 18% in 2006–2007^j Asymptomatic patients^k 40% were pauci-symptomatic^l Signs of proctitis observed in proctoscopy/sigmoidoscopy

disease, colorectal cancer and lymphoma [24], which is why they should be included in the differential diagnosis along with other ulcerative rectal STD such as syphilis and herpetic or cytomegalovirus proctitis. The case of lymphoma is

particularly relevant, because the tissue infiltration by lymphocytes and the immunohistochemical markers for the Epstein–Barr virus can be extremely confusing for the pathologist [52].

Table 2 Main characteristics of reported lymphogranuloma venereum cases in MSM between 1990 and 2009 (continued)

| Country | Rectal pain (%) | Anal discharge (%) | Constipation (%) | Blood loss (%) | Tenesmus (%) | Systemic ^a (%) | Inguinal nodes (%) | Anogenital ulcer (%) |
|----------------------|-----------------|--------------------|------------------|----------------|--------------|---------------------------|--------------------|----------------------|
| The Netherlands [38] | 2 | 2 | | | | | 24 | 9 |
| The Netherlands [43] | | 33.3 | | | | | 13.3 | 6.6 |
| The Netherlands [3] | | 77 | 77 | 61 | 15 | 15 | 0 | |
| France [11] | | | | | | | | |
| UK [5] | | | | | | 36.8 | 10.5 | |
| The Netherlands [14] | 74 | 85 | | 65 | | 41 | 24 | |
| Belgium [10] | | | | | | | | |
| Switzerland [8] | | | | | | | 0 | |
| The Netherlands [37] | | 44 | | | | | 13 | |
| UK [6] | 64 | 72 | 23 | 53 | 25 | 29 | 8 | 4 |
| UK [7] | | | | | | 15–24 ^b | | |
| The Netherlands [15] | 66 | 78 | | 89 | | 25 | | |
| Spain | | | | | | | | |
| Australia [29] | | | | | | | 9 | |
| Canada [28] | | | | | | | | |
| Sweden [16] | | | | | | | 13 | 13 |
| Germany [4] | | | | | | | 13 | |
| Italy [13] | | | | | | | 23 | |
| France [12] | | | | | | | | |
| Austria [2] | | | | | | | 13.3 | |
| France [33] | | | | | | 21 | | 57 |
| Canada [27] | 21 | 21 | 7 | | | 28 | 43 | 21 |
| Portugal [1] | | | | | | | | |

^a Systemic symptoms (weight loss, malaise, fever)

^b Systemic symptoms was registered in 15% in 2004–2005 and in 24% in 2006–2007

Diagnosis

First of all, it is of paramount importance to bear in mind that *LGV* proctocolitis will not be diagnosed if specific tests are not ordered, as routine smears and cultures performed in urethral or rectal samples do not identify this pathogen.

Correct diagnosis is essential as a prolonged treatment of 3 weeks is recommended for LGV infection, in contrast to infection with other *Chlamydia* serovars, where only 1 week (or a single azithromycin dose) is required.

Lymphogranuloma venereum was classically diagnosed by the Frei intradermal skin test, based on the delayed hypersensitivity reactions to chlamydial antigens, but this is no longer in use because of its low sensitivity and specificity. Direct identification of *C. trachomatis* from clinical specimens is the current standard. Before 2003 we did not have a routine test for diagnosing LGV since the tests that were available did not distinguish between the LGV and non-LGV serovars.

Initially, the laboratory diagnosis of LGV was based in either culture (which was rarely available in routine practice,

because it was slow and less sensitive), or nucleic acid amplification testing (NAAT) followed by genotyping of positive samples with PCR-based restriction fragment length polymorphism (RFLP) analysis and/or sequencing of the *omp1* gene encoding the major outer membrane protein. All this required a sophisticated laboratory setting and was time consuming. Since 2005, several fast molecular biological diagnostic tests that have a higher sensitivity have been widely available. In 2005, the first RT-PCR technique was developed to detect LGV serovars in a *C. trachomatis* PCR-positive sample using the polymorphic membrane protein H gene (*pmp* gene) as a PCR target because of its unique gap in LGV strains, making it highly specific [53]. This technique can detect the LGV serovars, but it cannot distinguish between them. A multiplex RT-PCR specific to serovar L2, and a quadriplex RT-PCR that simultaneously detects LGV and non-LGV serovars and mixed infections have been developed more recently [54, 55].

Chlamydia nucleic acids can be detected in urethral, endocervical, vaginal, pharyngeal or rectal swab specimens

and urine samples. However, the use of rectal swabs for nucleic acid testing is not cleared by the US Food and Drug Administration and in consequence is not recommended by the CDC yet [38], although initial data support its validity [56].

Serology has been replaced by direct detection tests. However, it could still be useful in selected cases. A high titre of antibody (with microimmunofluorescence or with complement fixation) in a symptomatic patient is strongly suggestive of LGV, but cannot distinguish between current or previous infection. Comparative studies between different serological tests are lacking, and there is no consensus regarding their interpretation.

Investigation of proctitis, with or without inguinal lymphadenopathy and genital ulcer, especially in the MSM group, should make the physician suspect LGV. Clinicians should not count on patient complaints and/or proctoscopic findings alone to identify LGV proctitis. Serovar typing is recommended in MSM with a PCR-positive anal swab for *Chlamydia* infection. If routine LGV serovar typing is not available or until definitive diagnosis, syndromic LGV management is proposed by some authors using clinical predictors of LGV proctitis in MSM with anorectal *Chlamydia* with either proctitis detected by proctoscopic examination, > 10 WBC detected on Gram stain smears from anal mucosa or presence of HIV infection [38].

Management

According to the current European and US STD guidelines the recommended treatment for LGV is doxycycline (100 mg orally twice a day for 21 days or as long as anorectal symptoms persist). An alternative regimen is erythromycin (500 mg orally four times daily for 21 days). However, this recommendation is not supported by randomised evidence in clinical trials, but by empirical data. Azithromycin (1.0 g orally once weekly for 3 weeks) has also been suggested as an alternative, but clinical data are lacking, as well as data regarding the new fluoroquinolones [57–60].

Patients should be followed up until symptoms have disappeared, and clinically reviewed at 3–6 weeks.

In uncomplicated chlamydial infections with non-LGV strains a single oral dose of 1 g azithromycin is enough or a shorter (1-week) course of doxycycline. In HIV-infected patients the recommended treatment is the same, even though randomised studies are lacking [58]. A delay in resolution may be observed in immunosuppressed persons, and prolonged therapy may be necessary. Sexual partners who have had unprotected contact with the patient within the previous 60 days of onset of clinical symptoms should

be screened or empirically treated with an LGV regimen [58, 60]. Aspiration of bubos may be necessary as well as surgical management of anorectal fistulas and strictures in advanced cases.

Patients should receive risk education counselling and be routinely screened for other STD, especially including HIV and hepatitis B and C.

Lymphogranuloma venereum should be a mandatory reportable disease in all countries, and contact tracing is of major importance to prevent further spread within the community.

Clinical implications

Clinicians should suspect LGV proctocolitis, especially in MSM presenting with colorectal symptoms like rectal pain, mucopurulent or bloody discharge, cramping abdominal pain, constipation, tenesmus leading to specific molecular biological diagnostic testing based on RT-PCR of a rectal swab with serovar typing. Systemic symptoms like fever, malaise and weight loss are relatively common. Simultaneous penile lesions and/or inguinofemoral lymphadenopathy are observed rarely in the present outbreak.

Early diagnosis and management are pivotal and furthermore have important public health implications, since the ulcerative character of the disease may facilitate transmission and acquisition of HIV and other STD, including hepatitis C. Screening for HIV, other STD and hepatitis C is mandatory since many of the described cases had concomitant infections. Contact tracing should be performed but it may be difficult given the anonymous nature of many sexual contacts in this core group.

Future challenges

There are still some pivotal questions to be answered concerning LGV proctitis. Diagnostic testing for *C. trachomatis* with LGV typing of *C. trachomatis*-positive samples in symptomatic men or contacts of men with LGV is currently recommended. The role of systematic screening for rectal LGV in stopping the transmission of LGV in HIV-infected MSM needs to be defined. Also, the usefulness of a shorter treatment with tetracyclines, macrolides or quinolones would be of great interest and may also have public health implications in reducing transmission. Moreover, there is a strong need for simpler and more affordable diagnostic methods, particularly those quick on-the-spot results, to help physicians with earlier diagnosis. It would be of great interest to perform prevalence studies among both HIV-positive and HIV-negative MSM.

Last but not least, there is an urgent need to implement regular and coordinated national and international surveillance programs in many countries in order to monitor the disease occurrence, to better identify patterns of disease and possible risk factors and to implement health service needs. This implementation would be of utmost urgency.

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