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LYMPHOGRANULOMA VENEREUM PRESENTING AS PERIANAL ULCERATION: AN EMERGING CLINICAL PRESENTATION?

Tajinder Singhrao
Elizabeth Higham
Patrick French

Corresponding author

Dr Patrick French

The Mortimer Market Centre, Camden Primary Care Provider Services, off
Tottenham Court Road, London, WC1E 6JB, United Kingdom.

Email: Patrick.French@Camdenpct.nhs.uk

Phone: 0203 3175246

Fax: 0203 317 5190

Co-Authors

Dr Tajinder Singhrao, The Mortimer Market Centre, London, UK

Dr Elizabeth Higham, The Mortimer Market Centre, London, UK

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Key Messages

1. These cases, to our knowledge are the first described LGV infections presenting with isolated perianal ulcer disease with normal proctoscopy and other causes excluded.
2. LGV typically presents with proctitis symptoms amongst HIV positive MSM within the UK.
3. We recommend testing for LGV infection in HIV positive MSM presenting with isolated perianal ulcer disease using chlamydia nucleic acid amplification tests (NAATs).
4. A positive rectal LGV Chlamydia NAAT with isolated perianal ulcer disease may provide insight into the biology and transmission of LGV, including sub-clinical proctitis and unrecognised ulceration.

Abstract

An outbreak of Lymphogranuloma venereum (LGV) infection has been recognised in the UK since 2004, predominantly affecting HIV positive men who have sex with men (MSM). Patients typically present with proctitis symptoms. Prevalence of rectal LGV in MSM attending STI clinics in London is estimated at 1%. Health Protection Agency (HPA) surveillance has shown a decrease in anorectal manifestations despite little demographic change. We report two cases of HIV infected patients presenting with isolated perianal ulcer disease. Both cases were confirmed to have rectal *Chlamydia trachomatis* specific DNA of an LGV associated serovar. As presentations of LGV diversify, further education and surveillance is needed in order to reduce transmission and prevent long-term complications. A strong argument already exists for the incorporation of Chlamydia nucleic acid amplification tests (NAATs) in the management of MSM with proctitis; this paper provides evidence that this should be extended to MSM with perianal ulcer disease.

Introduction

LGV, first identified in the UK in 2004, has become endemic among MSM. The prevalence of LGV amongst MSM (symptomatic and asymptomatic) attending London GU clinics in 2009 was estimated at 0.9% rectal and 0.04% urethral.[1] HPA surveillance from 2003-2008 found 849 cases of LGV, the majority in London (72%). All cases were male, predominantly white MSM (99%), co-infected with HIV(75%).[2] Risk factors for acquisition include co-infection with an STI, unprotected receptive anal intercourse, fisting, group and anonymous sex.

Historically LGV infection was an inguinal syndrome [3] including a transient primary ulcerative lesion with thrombolyphangitis and perilymphangitis resulting in tender inguinal lymphadenopathy. However an anorectal LGV syndrome among MSM is well recognised [4] and is the commonest presentation of LGV in the UK [5] with genital ulcers and inguinal symptoms rarely encountered.[6] HPA data since 2004 has consistently shown >75% of patients identified with LGV infection presented with proctitis.[7]

Case Report

A 28 year old white British male with HIV presented with a two week history of a single painful ulcer at the anal margin without rectal or inguinal symptoms and no proctitis on proctoscopy. This patient had been diagnosed with LGV and rectal gonorrhoea four months previously, presenting with proctitis, inguinal lymphadenopathy and an indurated perianal ulcer. LGV test of cure was negative two months following previous treatment.

A 45 year old white British male with HIV presented with a three day history of a single painful 0.5cm indurated perianal ulcer associated with tender unilateral inguinal lymphadenopathy without proctitis on proctoscopy. He subsequently developed fevers.

Chlamydia trachomatis specific DNA of an LGV associated serovar was identified on rectal (not ulcer) swabs taken from both patients. PCR tests for HSV1/HSV2/*T.pallidum* taken from the ulcers in both patients were negative. At presentation patient 1 was RPR negative (having been treated for primary syphilis 1 year previously) and patient 2 had negative *T.pallidum* serology. Urethral Chlamydia NAATs were negative in both patients. Patient 1 was diagnosed with hepatitis C at presentation.

Both reported unprotected receptive and insertive anal intercourse in the last 3 months. At presentation patient 1 was treated for an anal fissure and patient 2 for presumed herpes simplex virus (HSV) infection. Both patients received a three week course of doxycycline once found to be Chlamydia positive. Their symptoms resolved completely on treatment and both had a negative test of cure at 6 weeks.

Discussion

From 2004 to March 2010 we have seen 146 presentations of LGV at our centre accounting for 17% of cases reported to the HPA (unpublished data). Whilst largely amongst the HIV positive population, 22 /146 (15%) presentations affected HIV negative patients. Only 11/146 (7.5%) did not have proctitis symptoms, of these 2 were asymptomatic, 2 had isolated ulcer disease (the patients we report here) and 7 had genital symptoms, 4 with inguinal syndrome, some with systemic symptoms. We have seen 2 other patients with LGV and perianal ulcers who had concurrent proctitis. Both had negative PCR tests for HSV from the ulcer and *T.pallidum* serological testing was negative (*T.pallidum* PCR testing was not undertaken). Both had ulcer resolution with doxycycline. A case control study showed association between ano-rectal ulceration and LGV but it is not clear whether these patients had peri-anal, anal canal disease or concomitant proctitis. [8] We are not aware of any other published reports of patients with isolated perianal ulceration from LGV infection in which other causes of ulceration were excluded.

LGV associated genital ulcer disease is rare in the UK, explaining why our patients were not initially treated for LGV infection. A cohort of patients presenting to London GU clinics with inguinal syndrome and ulceration described 4 patients with genital ulceration, one with multiple genital and perianal ulcers.[9] Primary LGV erosions typically affect the genitalia and are classically painless.[6]

Neither of our patients had genital ulceration or proctitis. Both had positive rectal LGV chlamydia NAATs (HSV and syphilis were excluded on PCR testing). The validity of ulcer Chlamydia NAATs is uncertain and this paper suggests it may be a useful test. It raises questions regarding the biology and transmission of LGV, including possibilities of sub-clinical proctitis and ulceration.

Health promotion and behavioural intervention paramount in preventing and identifying cases of LGV infection and addressing sexual health needs of risk groups.[5,10] The HPA recommend LGV testing for all symptomatic HIV positive MSM.[2] There is a strong argument for rectal Chlamydia NAATs to be used in MSM with proctitis and this report provides evidence that rectal LGV testing should be extended to patients with anogenital ulcers.

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TS wrote the first draft of the paper. EH analysed the clinic data. EH and TS both contributed to subsequent drafts of the paper. PF contributed to subsequent revisions of the case report and is guarantor of this paper.

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