Lymphogranuloma Venereum and Proctitis

(LGV – see also genital ulcer protocol)

LGV accounts for about 5% of the rectal Chlamydia detections in MSM in Glasgow. Positive rectal chlamydia swabs in MSM with rectal symptoms or who have HIV infection must be sent for LGV testing

Management

Confirmed cases

First line:

Doxycycline 100mg po bd 21 days

NB warn re photosensitivity, oesophageal ulceration

Second line (if tetracycline allergy)

Second Line:

Erythromycin 500 mg QDS for 21 days

or Azithromycin 1g po stat followed by 1g weekly for three weeks

Contact management

Doxycycline 100mg po bd 21 days

(Offer if, sexual contact with a case of LGV within 4 weeks before onset of symptoms in index case or contact in last three months if asymptomatic LGV in an index case)

LGV epidemiology:

- LGV is caused by lymphotropic invasive strains of *C.trachomatis* (serovars L1,2,3)
- is now established as endemic in MSM in UK (the L2b strain is the dominant strain)
- Approximately 80 cases per quarter in UK
- Over 2000 cases to 2012
- 99% MSM
- LGV cases 8 times more likely to be HIV+ than nonLGV Chlamydia cases
- Strong association with sex-party scene (traumatic sex, toys, fisting and enema use where shared equipment)
- 78% of cases are HIV+.
- Hepatitis C co-infection rate of 14%
- Recreational drug use including poppers and ‘slamming’
- Most infections in UK MSM are rectal
- A UK-wide surveillance scheme is in place (most UK cases are seen in London, Manchester and Brighton)

Clinical features

LGV and proctitis/proctocolitis in MSM

Incubation period 1-4 weeks

- Increasingly, LGV is asymptomatic: approx 20% cases in recent HPA Colindale surveillance project, compared to initial outbreak where 95% LGV were symptomatic. Nearly all were HIV co-infected.
- Haemorrhagic, purulent proctitis and constipation (MSM) compared to classical heterosexual LGV patients who present with genital ulceration and inguinal lymphadenopathy.
- Proctitis: rectal pain, anorectal discharge, tenesmus, constipation, fever, malaise.
- 'Pre-symptomatic' patients: re-check when managing MSM found to have rectal Chlamydia that they have not developed symptoms suspicious of LGV.
- Genital ulcers and inguinal symptoms uncommon in MSM in UK.
- Genito-anorectal syndrome: chronic inflammatory response and destruction of tissue mimicking Crohn's disease and fistulae, strictures and granulomatous fibrosis.
- LGV can cause ulcerative pharyngitis

Investigations (specific for LGV):

- If symptomatic proctitis (or contact) then indicate this on Chlamydia test form and request specific LGV PCR (test will only be done if CT+) See below for further tests.
- Proctoscopy essential: document clinical appearance – blood, mucus, ulceration
- Gram stain slide: important to exclude GNDC but **poor correlation** between pus cell count and histological evidence of inflammation. DO NOT TREAT +++ RECTAL PUS CELLS AS AN STI
- Swabs of mucopus for gonorrhoea (culture and NAAT), of rectal mucosa for Chlamydia (NAAT), of mucosa/ulcers for HSV/TP PCR (remember to order syphilis PCR)
- HIV, hep C Ag and syphilis serology should be offered, including documented plan to retest at window period interval
- If inguinal lymphadenopathy take **a urethral swab** for LGV PCR and also (if fluctuant) take a small aspirate from the node through adjacent healthy skin in a sterile tube for LGV PCR (same as GC/CT NAAT tube)
- Serological testing is of no proven value due to poor specificity
- Given the LGV epidemiology, patients with proctitis should be managed as for LGV with an **extended course of 3 weeks doxycycline**

Partner notification:

- *All cases* should be seen by SHA for advice and information about LGV, their follow-up care and partner management

Follow-up care:

- Follow-up until signs/symptoms resolved
- Recheck that patients have not developed signs after an initial asymptomatic CT+ diagnosis Routine TOC is **not** required if 21d doxycycline used
- If TOC indicated, then do two weeks after completion of antibiotics
- Patients with genito-anorectal syndrome need surgical team review
- Repeat serology for HIV, hep C and syphilis

Differential diagnoses:

Proctitis/Proctocolitis

Infections acquired anally	**Infections acquired faecal-orally**	**Non-infectious causes**
T. pallidum	*E. histolytica*	Trauma
N. gonorrhoeae	*Shigella* spp.	Chemical irritants
C. trachomatis (LGV and non-LGV)	*Campylobacter* spp.	Allergies
HSV	Cryptosporidium	Inflammatory bowel disease

Additional investigations to be considered when reviewing the differential diagnosis

- Stool specimens - at least 3 stool specimens on alternate days -for ova, cysts, culture and *C. difficile* toxin (if history of recent antibiotic use)
- Where enteric fever is suspected, take **blood** cultures as well. Unwell patients with enteric fever should be admitted to Brownlee under the ID team.
- As well as above investigations for proctitis
- If these fail to reveal cause refer to Ruth McKee @ GRI or Helen Dorrance @ Victoria for sigmoidoscopy and biopsy