**CLINICAL VIGNETTE**

# Lymphogranuloma Venereum Proctitis

Hamed Nayeb-Hashemi, MD and Rimma Shaposhnikov, MD

***Case Presentation***

A 27-year-old male presented with 3 months of lower abdominal pain associated with defecation and sensation of incomplete evacuation. He reports the passage of mucus and bright red blood with each bowel movements over this period with no prior episodes. His initial visit was done via telemedicine and he appeared well at that time. Initial labs were notable for a fecal calprotectin level of 549ug/g with normal hemoglobin and normal C reactive protein level. He was referred for a diagnostic colonoscopy, which was notable for multiple raised ulcerations limited to the rectum (see Figure 1). The remainder of the colon was unremarkable. Histology showed focal erosion and ulceration without features of chronicity. On further questioning, our patient reported multiple male sexual partners with both receptive and insertive anal intercourse without regular use of condoms. Testing for sexually transmitted infection (STI) included rectal swab returning positive for Chlamydia trachomatis by PCR. He was diagnosed with Lymphogranuloma venereum proctitis and treated with a 21-day course of oral doxycycline with complete resolution of his symptoms.

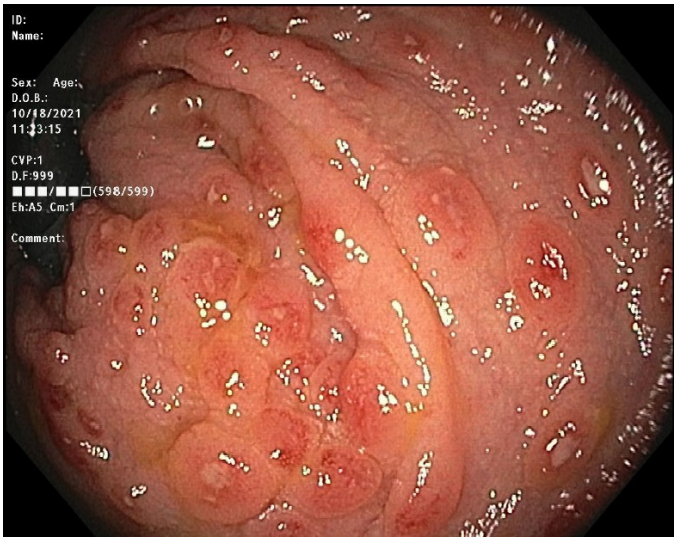

Figure 1 shows inflammation of the rectum with erythematous, edematous mucosa with associated aphthous ulcerations.

***Discussion***

Lymphogranuloma venereum (LGV) has traditionally been described as a genital ulcer disease associated with *C. trachomatis*. Historically, this disease was limited to tropical and resource limited countries. More recently, however, there are reports of proctitis in high income nations among men who have sex with men.[1] LGV infection is commonly associated with concurrent HIV infection and in patients without a history of prior HIV infection it should prompt screening. In a prior United Kingdom outbreak of LGV, concurrent HIV infection was found in 76 percent of cases with 4 percent representing a new diagnosis.[2] Additional risk factors for LGV include prior STI, unprotected anal intercourse, and concurrent genital ulcerative disease.

Three stages of LGV infection have been identified. The first stage is characterized by a genital or mucosal reaction at the initial site of inoculation. This follows an incubation period of 3-12 days. The initial stage can be difficult to identify due to the size and location of ulceration, as well as lack of associated symptoms. A secondary stage appears 6-12 weeks later and is associated with extension to the regional lymph nodes. In the inguinal form of disease, this presents as unilateral painful lymphadenopathy. Anorectal symptoms such as bleeding, tenesmus and rectal discharge occur in this stage.[3] The endoscopic appearance can mimic inflammatory bowel disease. Other causes of infectious proctitis including herpes simplex, syphilis and gonorrheal rectal infection should be considered and worked up. Late manifestations of LGV include development of fistula, strictures, and infertility.

The endoscopic appearance of LGV is non-specific and includes erythema, ulcerations, erosions and friable mucosa. These findings can be seen in ulcerative proctitis. Similarly, the histologic findings are often non-specific inflammatory change. Therefore, a high index of suspicion is needed to make a correct diagnosis. This highlights the importance of obtaining a sexual history in patients presenting with symptoms suggestive of proctitis. The diagnosis of LGV proctitis is best made using a nucleic acid amplification test for *C. trachomatis*. The differential diagnosis for the endoscopic findings includes inflammatory bowel disease though in the immunocompromised patient other infectious colitis should be considered including cytomegalovirus and herpes simplex.

Patients who are diagnosed with LGV should be screened for other sexually transmitted infections. Treatment of LGV is typically with doxycycline 100mg twice daily for a total of 21 days. In patients unable to take doxycycline, azithromycin 1g once weekly for three weeks can be considered. Patients with

resolved symptoms at the end of therapy, should have repeat testing 3 months after completion of therapy to assess for possible reinfection from an untreated sexual partner. Patients diagnosed with LGV should refrain from sexual contact until asymptomatic, and completion of antibiotic therapy. Screening of sexual partners is recommended with prophylactic therapy with seven days of doxycycline recommended for partners within 60 days of the index patient diagnosis.[4]

This patient presented with a not infrequent mimicker of inflammatory bowel disease. The clinical symptoms were suggestive of ulcerative colitis. However, a detailed sexual history and endoscopic findings led to the correct diagnosis of LGV proctitis. Diagnosis is correctly made using NAAT of rectal swabs and most cases, including this one, are successful treated with doxycycline.

**REFERENCES**


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