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Uncanny Proctopathy: A Case of Lymphogranuloma Venereum

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ABSTRACT

A 37-year-old man with a history of receptive and penetrating anal sex with men presented with abdominal pain, bright red blood per rectum, and fevers. Recent evaluation by his primary care doctor was notable for negative urine for *Neisseria gonorrhea* and *Chlamydia trachomatis*. Rectal swab on admission was positive for *C. trachomatis*. The patient was ultimately diagnosed with lymphogranuloma venereum, a disease typically seen in tropical climates, although it is more common now in western countries, specifically in men who have sex with men. Treatment consisted of a course of doxycycline for 3 weeks, with resolution of symptoms.

INTRODUCTION

Lymphogranuloma venereum is a sexually transmitted disease caused by the *Chlamydia trachomatis* serovars L1, L2, L2a, or L3.^{1,2} Classically it is an infectious disease limited to tropical climates, however its incidence has been increasing in western countries since the early 2000s.² The typical clinical progression and presentation can be seen in three stages.¹ The primary stage involves a genital ulcer, which typically lasts up to 4 weeks and heals on its own without other symptoms.¹ The secondary stage presents at 2–6 weeks with involvement of the lymph nodes, at times leading to formation of buboes or abscesses.¹ Anorectal involvement can also be associated with symptoms of rectal bleeding, anal pain, fever, and tenesmus.¹ The third stage occurs at variable times but is notable for chronic granulomatous inflammation leading to anal fistulae, strictures, infertility, and genital elephantiasis.¹

CASE REPORT

A 37-year-old man was referred to the emergency department by his primary care physician for evaluation of abdominopelvic pain, bright red blood per rectum, and fevers. He reported 10 weeks of daily, intermittent, sharp suprapubic abdominal pain that was often worse after eating and occasionally would awaken him from sleep. During the same time period, he noticed bright red blood and mucus coating his stool and in the toilet bowl. For a week prior to admission, he had been having intermittent daily fevers measuring up to 104°F. He denied any major medical problems, known sick contacts, and family history of inflammatory bowel disease (IBD). Sexual history was notable for both receptive and penetrating anal sex with men only, and condom use being infrequent. The patient noted he underwent laboratory testing 3 weeks prior with a negative serum human immunodeficiency virus (HIV) antigen/antibody and urinalysis negative for *Neisseria* and *Chlamydia*.

On presentation in the emergency department, the patient's vital signs were within normal limits, and physical examination was notable for tenderness to palpation in the suprapubic region without rebound, bilateral tender inguinal lymphadenopathy, and no lesions or ulcerations on his penis. Digital rectal exam was deferred per the patient's request due to pain. Complete blood count and comprehensive metabolic panel were unremarkable. Other notable lab results were negative stool culture, and negative HIV antigen/antibody. Computed tomography of the

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Figure 1. Axial computerized tomography with contrast of abdomen and pelvis showing irregular thickening of the rectum with surrounding perirectal fat stranding and regional lymphadenopathy.

abdomen and pelvis showed irregular thickening of the rectum with surrounding perirectal fat stranding and regional lymphadenopathy (Figure 1). Colonoscopy revealed numerous raised lesions approximately 5 mm in diameter coalescing in the distal rectum, with apical ulcerations and surrounding erythema, edema, and friability (Figure 2). Forceps biopsies indicated lymphoplasmacytic infiltration and crypt abscesses without viral inclusions or evidence of dysplasia (Figure 3).

A rectal swab was positive for *Chlamydia trachomatis*. Infectious Disease was consulted, and a course of doxycycline was initiated. The patient was seen in clinic after completing the antibiotic therapy, and he reported resolution of bright red blood per rectum and suprapubic pain; repeat rectal swab was negative for infection.

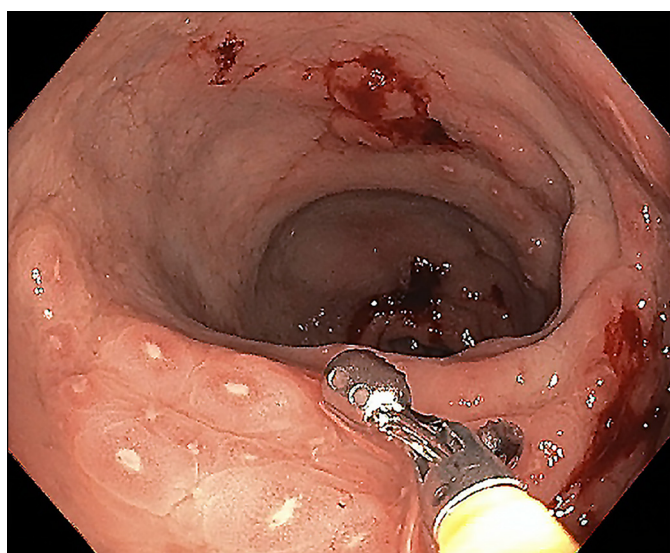


Figure 2. Colonoscopy revealing numerous raised lesions, approximately 5 mm diameter, coalescing in the distal rectum with apical ulcerations and surrounding erythema, edema, and friability.

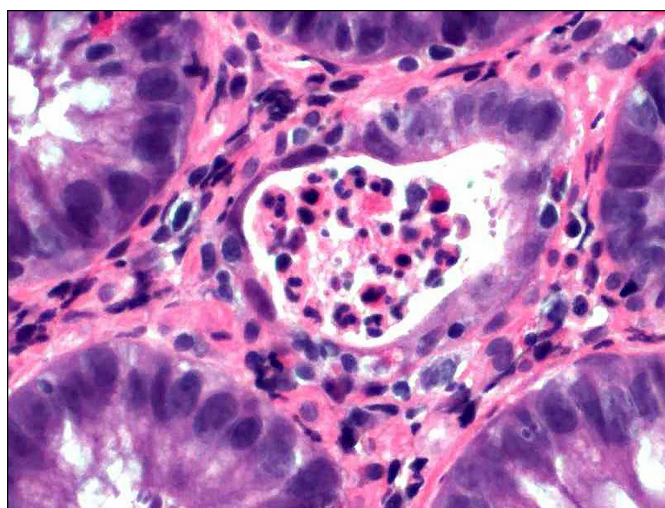


Figure 3. Rectal biopsy showing crypt abscesses without viral inclusions or evidence of dysplasia.

DISCUSSION

This case highlights the importance of obtaining a thorough sexual history and following testing guidelines for men who have sex with men because the clinical findings of lymphogranuloma venereum proctitis is often similar to IBD. The Centers for Disease Control and Prevention recommends annual screening for *Chlamydia* by checking urine and rectal swabs in all male patients who have sex with men, regardless of condom use.² Although this patient had undergone testing for sexually transmitted diseases several weeks prior to admission, that screening was inadequate because a rectal swab had not been performed. Rectal biopsies are rarely diagnostic because the histology that is typically seen with this condition is similar to IBD, with possible crypt abscesses, ulceration, and lymphoplasmacytic infiltration in the mucosa and submucosa.³ Treatment is a 21-day course of doxycycline, 100 mg twice daily, with testing to confirm clearance.² Patients' partners who were potentially exposed should be contacted and treated with 1 g azithromycin or with oral doxycycline, 100 mg twice daily for 7 days.²

DISCLOSURES

Author contributions: A. Zhornitskiy wrote the manuscript. D. Karunasiri provided the images. JH Tabibian revised the manuscript and is the article guarantor.

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Informed consent was obtained for this case report.

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