POSSIBLE RE-EMERGENCE OF LYMPHOGRANULOMA VENEREUM

The California Department of Health Services (CDHS) STD Control Branch has requested that local health departments alert the medical community about the appearance of Lymphogranuloma Venereum (LGV) in California. Cases have been identified in the United States, with at least one case in San Francisco. Two suspect cases are currently under investigation in Riverside County. Both individuals reside in eastern Riverside County.

Prompt diagnosis and appropriate treatment of LGV is essential to prevent a potential outbreak of this disease. The seriousness of the infection is demonstrated by the recent outbreak in the Netherlands among men who have sex with men (MSM). CDHS has provided the following guidelines for LGV diagnosis, and treatment;

1. Providers need to ask patients about gender of sex partners and assess behavioral risks which may result in sexually transmitted infections. For LGV, based on the epidemiology of the Netherlands outbreak, risk is primarily unprotected anal intercourse and/or other anal penetration such as fisting.
2. Clinicians who care for MSM should consider LGV in the diagnosis of compatible syndromes: a) proctitis/protocolitis which can be hemorrhagic and associated with constitutional symptoms, or b) tender inguinal lymphadenopathy associated occasionally with bubo formation and rarely with the presence of a painless genital ulcer. Clinicians should obtain serologic and microbiologic tests that diagnose C. trachomatis (CT) infections, including LGV.
3. The following two types of tests are recommended for the diagnosis of a suspected LGV case: a) a serologic test (e.g., microimmunofluoresence (MIF) or complement fixation (CF), and b) a microbiologic test, either Chlamydia tissue culture or Nucleic Acid Amplification Test (NAAT), on rectal specimens (anoscopy-directed specimens from ulcerative lesions are preferred over blind swabs or on specimens from bubo aspirates or ulcerative lesions in the presence of inguinal lymphadenopathy). Other serologic tests such as the immunofluorescence antibody (IFA) and enzyme immunoassay (EIA) should be avoided since they are less specific and/or cannot be quantitated.
4. Suspected cases should be reported to local health departments by both provider and laboratory. Providers should report within 24 hours after the patient is seen, if the patient was presumptively treated. Otherwise, providers should report within 24 hours after the test results are available. Laboratories should report within 24 hours after the test results are available. Until we have a better understanding of the epidemiology and clinical features of this infection, we are defining a suspected case as “any MSM with a compatible syndrome (e.g., proctitis or inguinal lymphadenopathy) and a positive lab test suggestive of a LGV infection (i.e., an MIF test with a titer of greater than 1:128 or a CF test with a titer

of greater than or equal to 1:64 and/or a positive tissue culture or a NAAT test from a rectal specimen, bubo, or ulcer in the presence of lymphadenopathy)".

5. The recommended treatment for LGV is a three-week (21-day) course of oral doxycycline 100 mg twice daily. Though data are lacking, some experts suggest that azithromycin (1gm orally in three weekly doses) is also effective in treating LGV.
6. While testing for CT/LGV is important in all suspected cases, providers should exercise clinical judgment in initiating presumptive treatment for LGV. They should consider factors such as severity of rectal symptoms in proctitis, presence of systemic symptoms that make LGV a more likely diagnosis, travel and exposure in Europe, and likelihood of follow-up.
7. Sex partners should be offered appropriate partner management services. Those with sexual contact within 60 days should be clinically evaluated and if symptomatic, managed as above. If asymptomatic, they should be treated with either oral doxycycline 100 mg twice daily for seven days or a single 1-gram oral dose of azithromycin.
8. In patients with suspected LGV, screening is warranted for other sexually transmitted infections, especially urethral or urine NAAT for CT or gonorrhea (GC), rectal and pharyngeal GC, syphilis, and HIV.

Providers should submit serologic and microbiologic specimens to their local public health laboratories for forwarding to the designated lab for the performance of these recommended tests.

Please contact the Public Health Laboratory at (951) 358-5070 for questions on specimen collection and/or submission.

Given the ulcerative nature of this more invasive Chlamydial infection with it's presumed increased risk of facilitating HIV transmission, suspect LGV cases should be immediately reported to the Department of Public Health by telephone at (951) 358-5107 or after hours at (951) 782-2974. Desert cases may be reported to (760) 778-2256.

Thank you for your attention to this re-emerging public health concern.