



# THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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February 2, 2005

## DOHMH Alert #4: Confirmed Lymphogranuloma Venereum (LGV) Infection in Two HIV+ New York City Residents

- Lymphogranuloma venereum (LGV) infection has been confirmed in two HIV-positive New York City residents; both are men who have sex with men (MSM) who presented with rectal symptoms (rectal pain, bloody rectal discharge).
- LGV is a systemic sexually transmitted disease (STD) caused by invasive strains of *Chlamydia trachomatis* (serovars L1, L2, L3).
- Recent outbreaks LGV among MSM, most of whom are HIV positive, have been reported in Europe, and cases among MSM are now being identified in the US.
- An outbreak of LGV could increase HIV transmission.
- Clinical and histologic features of LGV proctitis/proctocolitis may be confused with inflammatory bowel disease.
- Treat possible LGV cases presumptively -- do not await laboratory confirmation. Commercially available diagnostic tests cannot definitively diagnose LGV.
- If you suspect LGV in a patient, treat presumptively for LGV with 100 mg of doxycycline, twice a day for 21 days. Post-exposure prophylaxis for asymptomatic sex partners consists of 100 mg of doxycycline, twice a day for 7 days.
- **Notify the NYC Department of Health and Mental Hygiene (DOHMH) Bureau of Sexually Transmitted Disease Control (BSTDC) immediately of any possible LGV infections (212-788-4423), we will assist with diagnostic testing, case investigation, and partner notification.**

**Please distribute to colleagues in HIV Primary Care, Gastroenterology, Colorectal Surgery, Infectious Disease, Emergency Medicine, Family Practice, Internal Medicine, Laboratory Medicine, Obstetrics/Gynecology, Pediatrics, Adolescent Medicine, and Urology**

February 2, 2005

Dear Colleagues,

In late January 2005, LGV infection was confirmed by DNA sequencing of specimens from two New York City residents. LGV is a systemic infection caused by invasive strains of *Chlamydia trachomatis* (serovars L1, L2, L3). LGV can make it easier to get or spread HIV and other STDs, therefore identification and treatment of cases, and disease control measures, such as partner notification and post-exposure prophylaxis are of utmost importance.

An outbreak of LGV among MSM with high rates of HIV-coinfection in the Netherlands (1) was followed by reports of similar cases from other parts of Europe and the United Kingdom (UK) (2). Cases in the Netherlands and the UK have a similar profile: men who have sex with men presenting with hemorrhagic proctitis/proctocolitis; high rates (>70%) of HIV coinfection; multiple sex partners and engaging in unprotected anal intercourse.

In recent months, a small number of LGV cases have been identified in the US, including the recent 2 cases in New York City. The appearance of this unusual STD in two HIV-coinfected men raises concern for the spread of this serious infection among NYC residents, especially in light of ongoing increases in syphilis (3) and quinolone-resistant *Neisseria gonorrhoea* (4,5) among MSM in NYC.

The primary lesion of LGV is a small genital or rectal papule, ulcer or erosion that appears at the site of inoculation and may or may not be painful. These lesions may be clinically similar to the lesions of genital herpes, primary syphilis, or chancroid. Among MSM, lesions may be anorectal and therefore not easily observed. The incubation period from exposure to developing a lesion is 3-30 days.

A secondary stage of LGV infection (the anogenitoretal, or inguinal syndromes) may occur several months after exposure. The anogenitoretal syndrome is characterized by hemorrhagic or non-hemorrhagic proctitis/proctocolitis, with purulent, mucous, or bloody anal discharge, rectal pain/spasms, tenesmus, or constipation (6). The clinical and histologic findings of early LGV proctocolitis can be similar to those of inflammatory bowel disease. The inguinal syndrome is characterized by inguinal or femoral adenopathy that may go on to suppurate and ulcerate (buboes). Untreated, the secondary stage manifestations of LGV may progress to genitoretal fistulae, strictures, or genital elephantiasis.

**Any patient meeting the following case definition for possible LGV infection must be reported to the Health Department:**

#### **POSSIBLE LGV - CASE DEFINITION**

**Anogenitoretal syndrome:**

Person (male or female) presenting with bloody proctitis/proctocolitis (which may include purulent, mucous, bloody anal discharge, rectal bleeding, rectal pain/spasms, tenesmus, constipation) and a history of unprotected receptive anal intercourse in the previous 6 months.

**Lymphadenopathy syndrome:**

Persons presenting with tender inguinal or femoral lymphadenopathy, with a history of unprotected intercourse in the previous 6 months.

#### **MEDICAL HISTORY WHEN EVALUATING A PATIENT YOU SUSPECT MAY HAVE LGV**

Be sure to obtain a sexual history when evaluating a patient for LGV, and be prepared to provide the following when reporting a possible case:

- Sex partner information – gender of sex partners and number of sex partners in past 6 months
- Sexual behavior - specifically whether the patient has engaged in unprotected anal intercourse in the past 6 months.

- Travel history – specifically, sex while traveling in Europe or the UK; or sex with partners who have traveled in Europe or the UK within the last 6 months.
- Current HIV status

Any patient with possible LGV infection should be tested for other STDs, including syphilis and chlamydia, herpes, and possibly chancroid and offered HIV testing if not already known to be HIV-positive. Consider other causes for bloody rectal discharge, such as inflammatory bowel disease and sexually transmitted enteric diseases (such as amebiasis and shigellosis), and test accordingly.

#### **LABORATORY TESTING**

Commercially available tests (eg. culture, nucleic acid amplification, nucleic acid hybridization, and serologies), can be used to confirm chlamydial etiology, but do not distinguish between chlamydial serovars and cannot, therefore, be used to confirm a diagnosis of LGV.

Serologic test results consistent with (but not diagnostic of) a LGV include a titer  $\geq 1:64$  on a complement fixation test for *C. trachomatis* or a high titer on a microimmuno-fluorescence serologic test for *C. trachomatis* (typically  $> 1:128$ , but can vary by laboratory).

The BSTDC is working with the federal Centers for Disease Control and Prevention to provide serovar-specific, LGV testing. When evaluating a patient with possible LGV infection, please contact the BSTDC of the NYC DOHMH to discuss specimen collection and arrange for testing.

#### **TREATMENT FOR LGV**

Treatment of possible LGV cases should not await laboratory confirmation. Patients suspected of having LGV infection should be treated presumptively with:

**Recommended regimen:** Doxycycline, 100 mg po BID X **21 days**

**Alternative regimen:** Erythromycin base, 500 mg po QID X **21 days**

**Some experts recommend:** Azithromycin, 1.0 g po Q week for **3 weeks**  
(however data are not available to judge the efficacy of this regimen for LGV)

#### **MANAGING THE SEX PARTNERS OF PATIENTS WITH SUSPECTED LGV**

BSTDC should be notified of any sex partners during the 6 months prior to symptom onset as these partners should be evaluated, tested for LGV, and treated, so that we can stop this outbreak in its early stages. Symptomatic sex partners should be treated presumptively for LGV. Asymptomatic sex partners should be given post-exposure prophylaxis consisting of 100 mg of doxycycline, twice a day for 7 days.

#### **REPORTING CASES TO THE BUREAU OF SEXUALLY TRANSMITTED DISEASES**

Please report by telephone all cases of possible LGV to the Bureau of STD Control of the NYC DOHMH by calling (212) 788-4423 and asking for the 'LGV Desk.' The Bureau will assist with LGV-specific testing, case investigation, partner elicitation, notification and treatment.

## Summary

### For Patients with Possible LGV (Anorectal or Lymphadenopathy) Syndrome

- Obtain thorough sexual history and travel history
- Treat presumptively/ prophylactically
- Report suspected case to Bureau of STD Control (212) 788-4423 to arrange serovar-specific testing and partner management.

Sincerely,

*Susan Blank, MD, MPH*

**Susan Blank, MD, MPH**  
Assistant Commissioner

*Julia Schillinger, MD, MSc*

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### References:

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- (2) Health Protection Agency. Initial results of enhanced surveillance for lymphogranuloma venereum (LGV) in England. CDR Weekly 2005: 15 (4).
- (3) CDC. Primary and secondary syphilis---United States, 2002. MMWR 2003;52:1117--20.
- (4) Health Alert Network. [2004 Alert #8: Fluoroquinolone-resistant gonorrhea, NYC \(April 30, 2004\)](http://www.nyc.gov/health). <http://www.nyc.gov/health>
- (5) CDC. Increases in fluoroquinolone-resistant *Neisseria gonorrhoeae* among men who have sex with men---United States, 2003, and revised recommendations for gonorrhea treatment, 2004. MMWR 2004;53:335--8.

- (6) Perine PL, Stamm We. Lymphogranuloma venereum. In: Holmes KK, Mardh PA, Sparling PF, et al., eds. Sexually transmitted diseases. New York, NY: McGraw-Hill; 1999: 423-32.