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# LYMPHOGRANULOMA VENEREUM (LGV) IN MSM

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LGV is uncommon in developed countries, however, outbreaks have recently occurred among men who have sex with men (MSM). Most of these men have presented with proctitis. Typical symptoms include rectal pain, discharge, tenesmus, and constipation. Asymptomatic cases of rectal infection have also been found.

A high proportion of MSM with LGV have been HIV positive. LGV can also cause genital ulceration with inguinal bubo formation.

Some LGV cases seen among Melbourne MSM have reported overseas contact while others have not.

LGV is caused by *Chlamydia trachomatis* serovars L1, L2, and L3. The L2 serovar has predominated among LGV cases in MSM.

## DIAGNOSIS

LGV will be detected using nucleic acid amplification testing for chlamydia. The LGV serovars can specifically be identified by amplification and sequencing of the *C. trachomatis* omp1 gene.

All MSM who present with symptoms of proctitis should be tested for chlamydia using a rectal swab. If the chlamydia result is positive, then the testing laboratory should be notified so that the specimen can be forwarded to MDU for sequencing of the omp1 gene to identify LGV. Aspirated fluid from inguinal bubos should also be sent for chlamydia testing and genotyping. It is MSHC policy to forward all positive anal chlamydia swabs in HIV positive MSM for genotyping even among those who are asymptomatic for proctitis.

Men who are asymptomatic contacts of LGV should

be screened for chlamydia in the usual way (urine and rectal swab). If these are positive then MDU should be contacted so genotyping can be ordered as above. Serology for *C. trachomatis* can sometimes assist in the diagnosis of LGV, e.g., when the rectal swab is negative or if it is not possible to amplify the omp1 gene. High antibody titres are often found with LGV, which is not usually the case with uncomplicated genital chlamydial infection. Serology does not, however, distinguish between LGV and non-LGV serovars.

## TREATMENT

All MSM who present with symptomatic proctitis that is positive for rectal *C. trachomatis* should be treated presumptively for LGV, irrespective of the result from omp1 gene sequencing (which may not be available for several weeks).

Recommended treatment for LGV: • Doxycycline 100mg orally bd for 21 days OR • Erythromycin 500mg orally qds daily for 21 days. Alternative treatment: • Azithromycin 1gm orally weekly for 3 weeks. Doxycycline and Erythromycin are preferred over azithromycin as clinical data are lacking for azithromycin.

## FOLLOW UP

All MSM who have a positive anal chlamydia test should be carefully assessed for symptoms of proctitis (see above). Men who have positive anal chlamydia results, whether LGV or otherwise, should have a repeat anal swab for chlamydia 3 months following treatment.

If symptoms are present, these men should be treated for LGV. If they are asymptomatic, they can be treated using one of the standard treatments for non-LGV chlamydia,

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## **CONTACTS**

Contact tracing for LGV should be initiated. All asymptomatic sexual partners of men with LGV should be screened for LGV (see above) and offered treatment with azithromycin 1gm at the initial visit.

## **NOTIFICATION**

LGV is notifiable to the Victorian Health Department by doctors and laboratories and a notification form should be completed.