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FROM:

HIV, STD and Hepatitis Prevention Branch
Public Health Services
Health and Human Services Agency
County of San Diego

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Lymphogranuloma venereum (LGV) Update

The outbreak of LGV that is occurring among men who have sex with men (MSM) in the Netherlands (See STDHEP Update No. 14, October 28, 2004) has spread to the U.S. In November a case was identified in a gay man seen at the San Francisco city STD clinic and a retrospective review of men with positive rectal chlamydia tests was performed and stored serum indicated that 3 other cases had occurred during the last 4–5 months. The most recent report indicates that a total of 9 cases have been identified through 2004. Another case has been reported from New York City.

None of the cases have had direct contact with the Netherlands and suggests that LGV is being transmitted among MSM in the United States. Until the scope of this problem is clearer, **we urge all physicians to be on the alert for suspect cases and to report any as soon as possible by telephone (619-692-8501) or fax (619-692-8551) using a CMR report.** Direct discussion with the STD Control Officer, Dr. Robert A. Gunn would be appreciated (619-692-8614/8082).

Sexual History - Clinicians should ask patients about gender of sex partners and assess behavioral risk that 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.

Clinical Syndrome – LGV is caused by an invasive form of *Chlamydia trachomatis* that can cause considerable morbidity and serious life-threatening sequelae. Primary infection may be asymptomatic or denoted by a small, painless ulcer occurring 3 – 30 days after exposure. More commonly, patients can have severe symptomatic manifestations. Clinicians who care for MSM should consider LGV in the diagnosis of compatible syndromes: 1) proctitis/proctocolitis which can be hemorrhagic and includes anal/rectal ulcerations and is associated with constitutional symptoms or 2) tender inguinal lymphadenopathy associated occasionally with bubo formation (large inguinal lymph node swelling with ulceration and drainage) and rarely with the presence of a painless genital ulcer(s). Clinicians should obtain serologic and microbiologic tests that diagnose *C. trachomatis* (CT) infections, including LGV.

Laboratory Tests - The following two types of tests are recommended for the diagnosis of a suspected LGV case: 1) 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, or 2) a serologic test (either microimmunofluorescence [MIF] or complement fixation [CF]). **Note:** 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.

Specimen Processing – The County Public Health Laboratory does not provide these tests (since the disease has been so rare in the U.S.), but testing is available **for suspect cases** at the University of California Chlamydia Laboratory, in San Francisco. All specimens sent to this laboratory **must include a clinical description** indicating signs and symptoms compatible with the suspect case definition (see below). Clinical microbiology laboratory directors in San Diego have received information regarding specimen processing (also see details at the end of this e-mail).

Suspect Case Definition - A suspect case is defined 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 $\geq 1:128$ or a CF test with a titer $\geq 1:64$ and/or a positive tissue culture or a NAAT test from a rectal specimen, bubo, or ulcer in the presence of lymphadenopathy).”

Case Reporting – Clinicians should report within 24 hours any suspect case, especially if the patient was treated presumptively. Otherwise, report as soon as the results are available.

Treatment - 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 (1 gm orally in three weekly doses) is also effective in treating LGV.

Partner Notification - 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. Public Health STD Field and Community Services can provide assistance (619-692-8501).

Other STDs - 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 culture, syphilis, and HIV.

LGV Specimen Collection

- Specimens for chlamydia identification can be detected by using any standard kit for nucleic acid amplification test (NAAT) using the swab and the medium supplied with the

kit. If these test kits are not available, collect a specimen using a dry sterile swab and place in a dry transport tube that does not contain fluid or jelly medium, or place in a universal NAAT transport medium tube.

- Serology: Collect a blood specimen (red-top tube or red/gray-top) and separate serum (2 ml required).
- Specimens can be sent to your usual laboratory service which should forward to the University of California Chlamydia Laboratory or can be sent directly to

University of California Chlamydia Laboratory
Box 0842, Building 30, Room 416, 1001 Potrero Avenue
University of California, San Francisco
San Francisco, CA 94143
Phone: (415) 476-2370
Fax: (415) 821-8945

- Serologic and swab specimen should be sent under cold pack conditions (e.g. gel pack).

Remember a clinical history must accompany the specimen. Questions about specimen collection can be addressed by the county Public Health Laboratory at 619-692-8500, ask for Klaus Steueman or Let Negado.

Meningococcal C Infection among MSM – British Columbia

The British Columbia (B.C.) health department has identified 19 cases of meningococcal C disease in 2004. Since October, 6 cases have occurred among gay men and 3 were fatal infections. There has been no connection among the cases – no common friends or attendance at social clubs or social events. Clinicians should consider meningococcal C infection in MSM presenting with compatible neurologic signs and symptoms, especially if there is a history of travel to B.C. A prompt diagnostic approach and presumptive treatment would be indicated.

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To join the STDHEP Email List, send an email to STDHEP.HHSA@sdcounty.ca.gov with “Join” in the subject line.

You can also call Craig Sturak, 619-692-8369, and ask to be added to the list.