Lymphogranuloma venereum: here to stay?

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In 2005, this journal published a report from The Netherlands of an unusual presentation of lymphogranuloma venereum (LGV) in a man with HIV infection.1 That article was the first evidence of a significant re-emergence of the disease in gay men. Over the following 5 years, articles in this journal and others have documented cases and clusters of LGV from many countries in Europe and North America as well as from Australia and New Zealand. The cases have been in gay men, many of whom are coinfected with HIV and some with hepatitis C. The spectrum of clinical presentation has been wide, the majority having proctitis, rather fewer with classical urethral syndrome and others being asymptomatic.2–4 Expanded diagnostic capacity, greater awareness among clinicians and patients, and new forms of surveillance have undoubtedly played a role in increasing detection of the disease.

A short report from Italy provides a picture of 13 cases diagnosed in Italy over a 2-year period.5 Early cases from 2006 reported sexual contact in other European countries, whereas more recently the infection appeared to be locally acquired. A paper from the UK reports a multicentre case finding exercise among gay men attending genitourinary medicine clinics to establish whether there is a reservoir of undiagnosed infection that is being missed by current testing protocols.6 The paper reports a rectal LGV positivity of just less than 1% in 6778 specimens, with almost all cases being asymptomatic. In contrast, LGV was rare in the urethra with an estimated prevalence of less than 0.1%. A linked study of chlamydia in gay men at a large centre in London found similar rates of LGV infection: 1.1% in the rectum and 0.03% in the urethra.7 They identified six asymptomatic cases of rectal LGV.

Many questions about LGV still remain, for example the exact mode and risks of transmission given the imbalance between genital and rectal infection, and the extent of the disease in the wider population. The high degree of coincident infection with HIV is still a puzzle—possible explanations include biological synergy, density of sexual networks, differential case finding or a combination of factors. For now, the recommendations regarding LGV remain as before: there needs to be a high degree of awareness and clinical suspicion, including of possible atypical presentations. People who have symptoms suggestive of LGV or who are positive for chlamydia infection should be tested for LGV infection.8,9 Treatment of suspected and confirmed cases and contacts should be with 3 weeks of doxycycline. A recent study of the persistence of different chlamydial serovars during the course of treatment supports the arguments that shorter courses of treatment are unlikely to be effective for LGV infection.10 In the light of the unanswered clinical and epidemiological questions, it looks likely that LGV is here to stay—at least for now.

Competing interests: HW and RM are editors of the journal, Sexually Transmitted Infections.

REFERENCES