Session title: Clinical Cases

Session date: Thursday 28 June 2012; 2.45 pm—3.30 pm

C1 PHARYNGEAL LYMPHOGRANULOMA VENEREUM: FOUR CASES IN MEN WHO HAVE SEX WITH MEN

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Background Lymphogranuloma venereum (LGV) is an established cause of proctitis in men who have sex with men (MSM). In the UK, testing for pharyngeal *Chlamydia trachomatis* (CT) is not routine, and LGV typing is seldom performed.
Objective To describe clinical features of four cases of pharyngeal LGV seen across three different urban GUM/HIV clinics, all of who had LGV-specific DNA detected at this site.
Case reports All four cases occurred in MSM; their past STI histories included HIV (2), syphilis (3) and hepatitis C (2; one diagnosed after LGV infection). Two cases had no oropharyngeal symptoms or local lymphadenopathy (LN) but had symptomatic LGV proctitis. One case had severe odynophagia, a tongue ulcer and cervical LN, and the final case reported severe pharyngitis with large unilateral cervical LN 10 days prior. Three of the four had concurrent rectal LGV infection. The infections responded to doxycycline: 21 days was given in two cases, and the other two received 7 and 14 days treatment, respectively. Test of cure swabs performed at 6 weeks to 5 months following treatment were negative in all cases. Three MSM had new STIs diagnosed at the time of their Test of cure.
Conclusion/Learning points We describe a variety of clinical presentations of pharyngeal LGV infection in MSM. The oropharynx may act as reservoir for CT, and possibly LGV, and routine screening should be considered at this site for all MSM. The absence of localised symptoms does not exclude pharyngeal LGV infection. Symptomatic oropharyngeal LGV infection is probably rare but should be considered in the differential diagnosis of MSM with unusual or severe symptoms/signs at this site. There are no guidelines for treating pharyngeal CT or LGV infection, but treatment with 1- to 3-week regimens of doxycycline was effective. Ongoing high-risk sexual behaviour in this population makes outbreak containment difficult.

C2 PENILE INTRAEPITHELIAL NEOPLASIA: IMPORTANT LESSONS FROM A CASE SERIES

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Background BASHH Guidelines recommend a biopsy to exclude premalignant conditions in persistent balanitis. PIN is a well recognised condition that can be difficult to identify. In UK GUM clinics, the incidence of reporting of PIN is rare compared to international studies raising the possibility of under-diagnosis. Locally, our clinic guidelines and policies have changed in line with BASHH guidance.
Aims We describe the clinical presentation, diagnostic process and management of PIN cases presenting to the sexual health clinic.
Results Five cases were identified from August 2010 to March 2011. The median age was 38 years (range 31—52). 1/5 was an HIV infected MSM. Duration of symptoms ranged from 3 months to 18 years. 3/5 were initially managed inappropriately; having a delayed biopsy. In each case the condition manifested differently; with clinical appearances ranging from solitary hypertrophic lesions to multiple verrucous and leukoplakic lesions. The HIV positive patient had the most atypical and florid lesions. All of the men were uncircumcised; 2/5 were current smokers and 2/5 were previous smokers. One case had possible previous exposure to agricultural chemicals. Histologically: all biopsies had evidence of HPV infection, 4/5 had PIN3 and 1 had PIN1. 2/5 also had anal intraepithelial neoplasia; 1 presented to the surgeons with an anal lesion, but his penile lesion was missed. All were referred to local urology and three were reviewed further at a tertiary centre. 1/5 was treated with topical imiquimod only, 2/5 were treated initially with topical imiquimod then subsequent surgery with resolution of lesions and two had a surgical intervention as first line treatment.
Discussion Men presenting with atypical penile lesions should have a penile biopsy in line with BASHH guidance and a high index of suspicion for other genital dysplastic conditions, for example, AIN and clear local pathways for referral should be in place.

C3 AN OLD FRIEND, A NEW FACE: PRIMARY SYPHILIS PRESENTING AS A BUBO WITH BALANITIS AND LYMPHOCOELE

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Background Follman balanitis as an initial presentation of primary syphilis is well described and syphilis is a known cause of lymphocoele. Inguinal buboes are commonly seen in chancroid and lymphogranuloma venereum but not in syphilis. We report an unusual case of syphilis presenting with balanitis, lymphocoele and bubo together.
Case report A 24-year-old man presented with a painless lump in the right groin for 2 weeks and a swelling and red spot on the glans penis for 2 days. He had three casual male partners all within the UK in the preceding 3 months and had an episode of unprotected insertive anal intercourse 2 months before, with no episodes of vigorous intercourse or masturbation. There was a 2 cm fluctuant non-tender lymph node in the right groin, a non-tender cord-like swelling under the coronal sulcus on the same side and a well defined erythematous patch with an infiltrated base on the glans. No other local or systemic signs. A dark field microscopy preparation from the balanitis was negative; one from the lymph node aspirate showed characteristic motile spirochaetes typical of *Treponema pallidum*; a positive Treponemal EIA-IgM and RPR (titre of 1:4) confirmed a diagnosis of syphilitic bubo with Follman balanitis and lymphocoele. The lymph node aspirate on gram staining showed pus cells. Chlamydia NAAT (SDA) was negative from the balanitis and lymph node aspirate. The rest of the STI screen including HIV serology was negative. He was treated with Benzathine penicillin 2.4 m IU IM weekly for 2 weeks with clinical resolution. All three contacts had been informed.
Discussion (1) Balanitis is a common presentation in GUM clinics and this case highlights the importance of including syphilis in the differential diagnosis. (2) Early syphilis can cause lymphocoele and inguinal bubo. (3) Aspiration of lymph nodes for dark field microscopy examination enabled point of care diagnosis and facilitates early treatment and partner notification.