CLINICAL GUIDELINE

Lymphogranuloma Venereum and Proctitis

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Lymphogranuloma Venereum and Proctitis

(LGV – see also Genital Ulcer Protocol)

Key points and what's new

Mpox virus must be considered in anyone presenting with suspected sexually-acquired proctitis

Management of acute undifferentiated proctitis in Sandyford may be subject to change due to infection control concerns

There have been no updates to national LGV guidance since 2013

LGV must be excluded in MSM with rectal symptoms and/or who are HIV positive

Management

Confirmed cases

First line:

Doxycycline 100mg po bd 21 days

NB warn re photosensitivity, GI disorders

Second Line:

Erythromycin 500 mg QDS for 21 days
or Azithromycin 1g po stat followed by 1g weekly for three weeks

Contact management

Doxycycline 100mg po bd 21 days

(Offer if sexual contact with a case of LGV within 4 weeks before onset of symptoms in index
case or contact in last three months if asymptomatic LGV in an index case)

Certain medications including fluconazole, macrolide and quinolone antibiotics cause QT prolongation and should not be prescribed with interacting medications. This is unlikely to be of clinical significance for stat doses but is important for longer

courses. Please use BNF Interaction Checker to ensure these medications are safe to prescribe for your patient and discuss with a senior colleague if necessary.

LGV epidemiology:

- LGV is caused by lymphotropic invasive strains of *C.trachomatis* (serovars L1,2,3)
- is now established as endemic in MSM in UK with around 1000 reports per year in England
- LGV cases 8 times more likely to be in people living with HIV than non LGV chlamydia cases
- Strong association with sex-party scene (traumatic sex, toys, fisting and enema use where shared equipment)
- 70% now in those HIV negative or unknown
- Hepatitis C co-infection rate of 14%
- Recreational drug use including poppers and 'slamming'
- Most infections in UK MSM are rectal
- A UK-wide surveillance scheme is in place (most UK cases are seen in London, Manchester and Brighton)

Clinical features

LGV and proctitis/proctocolitis in MSM

- Incubation period 1-4 weeks
- Increasingly, LGV is asymptomatic: approx 20% cases in HPA Colindale surveillance project, compared to initial outbreak where 95% LGV were symptomatic. Nearly all were in people living with HIV.
- Haemorrhagic, purulent proctitis and constipation (MSM) compared to classical heterosexual LGV patients who present with genital ulceration and inguinal lymphadenopathy.
- Proctitis: rectal pain, anorectal discharge, tenesmus, constipation, fever, malaise.
- 'Pre-symptomatic' patients: re-check when managing MSM found to have rectal chlamydia that they have not developed symptoms suspicious of LGV.

- Genito-anorectal syndrome: chronic inflammatory response and destruction of tissue mimicking Crohn's disease and fistulae, strictures and granulomatous fibrosis.

Genital ulcers and inguinal symptoms uncommon in MSM in UK.
LGV can cause ulcerative pharyngitis

Investigations (specific for LGV):

- If symptomatic proctitis (or contact) then indicate this on chlamydia test form and request specific LGV PCR (test will only be done if CT+) See below for further tests.
- Proctoscopy essential (subject to mpox infection control): document clinical appearance – blood, mucus, ulceration
- Gram stain slide: important to exclude GNDC but **poor correlation** between pus cell count and histological evidence of inflammation. DO NOT TREAT +++ RECTAL PUS CELLS AS AN STI
- Swabs of mucopus for gonorrhoea (culture and NAAT), of rectal mucosa for Chlamydia (NAAT), of mucosa/ulcers for HSV/TP PCR (remember to order syphilis PCR)
- HIV, Hep C PCR and syphilis serology should be offered, including documented plan to retest at window period interval
- If inguinal lymphadenopathy take **a urethral swab** for LGV PCR and also (if fluctuant) take a small aspirate from the node through adjacent healthy skin in a sterile tube for LGV PCR (same as GC/CT NAAT tube)
- Serological testing is of no proven value due to poor specificity
- Given the LGV epidemiology, patients with proctitis should be managed as for LGV with an **extended course of 3 weeks doxycycline**

Partner notification:

- *All cases* should speak to a SHA for advice and information about LGV, their follow-up care and partner management

Follow-up care:

- Follow-up until signs/symptoms resolved
- Recheck that patients have not developed signs after an initial asymptomatic CT+ diagnosis Routine TOC is **not** required if 21d doxycycline used
- If TOC indicated, then do two weeks after completion of antibiotics

- Patients with genito-anorectal syndrome need surgical team review
- Repeat serology for HIV, hep C and syphilis

Differential diagnoses:

Proctitis/Proctocolitis

Infections acquired anally	**Infections acquired faecal-orally**	**Non-infectious causes**
T. pallidum	*E. histolytica*	Trauma
N. gonorrhoeae	*Shigella* spp.	Chemical irritants
C. trachomatis (LGV and non-LGV)	*Campylobacter* spp.	Allergies
HSV	Cryptosporidium	Inflammatory bowel disease
Monkeypox virus		

Additional investigations to be considered when reviewing the differential diagnosis

- Mpox virus is now a critical differential diagnosis in proctitis
- Stool specimens - at least 3 stool specimens on alternate days -for ova, cysts, culture and *C. difficile* toxin (if history of recent antibiotic use)
- Where enteric fever is suspected, take **blood** cultures as well. Unwell patients with enteric fever should be admitted to hospital under the ID team.
- As well as above investigations for proctitis
- If these fail to reveal cause refer to relevant colorectal surgery unit via SCI Gateway

References

2019 European guideline on the management of lymphogranuloma venereum. IUSTI guideline. Available at: https://iusti.org/treatment-guidelines/. [Accessed 17/09/2024]

2013 UK National Guideline for the management of lymphogranuloma venereum: Clinical Effectiveness Group of the British Association for Sexual Health and HIV (CEG/BASHH) Guideline development group. BASHH guideline. Available at: https://www.bashh.org/guidelines/ [Accessed 17/09/2024]

Public Health England. Trends of Lymphogranuloma venereum (LGV) in England, 2019. Health Protection Report 14 (23) Dec 2020]. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011030/hpr2320_LGV-11.pdf [accessed 17/09/2024]

UKHSA Mpox (monkeypox) guidance https://www.gov.uk/government/collections/monkeypox-guidance [accessed 17/09/2024]