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Four cases of lymphogranuloma venereum in Hamburg, 2003

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Commentary by Viviane Bremer, Robert Koch-Institut, Berlin, Germany

In the course of 2003, four men were diagnosed with lymphogranuloma venereum (LGV) at the Hamburg Institut für interdiziplinäre Infektiologie und Immunologie. All were men who have sex with men (MSM). LGV was also suspected in two other patients.

LGV is caused by infection with *Chlamydia trachomatis*, serotypes L1, L2 and L3. Cases in western Europe are rare. LGV is confirmed if the causative agent can be microbiologically determined as serotype L1, L2, or L3, and if serology (IgG titre ≥ 1024 or ELISA) and PCR testing are positive for *Chlamydia trachomatis*. A case is classified as suspected if there are typical clinical symptoms and serology and PCR are positive.

Clinical presentation and course

In January 2003, a 49 year old man presented at the Institut clinic with therapy-resistant ulceration of the anal region and lymphadenitis in the groin. Laboratory testing on a rectal swab revealed *Chlamydia trachomatis* as the causative agent. The anal lesions healed after doxycycline therapy.

During June and December 2003, three other patients presented at the clinic with lesions of the penis and lymph node swellings in the groin. They had neither urethritis nor proctitis. All three cases were laboratory confirmed as LGV. After several weeks of doxycycline therapy, all three recovered fully.

Diagnosis

The infection with *Chlamydia trachomatis* was confirmed in all cases by strand displacement amplification technique on genital swab samples and material from lymph node punctures. Typing by sequence analysis of ompA PCR products of all of the four isolates confirmed different strains. The existence of other sexually transmitted infections was ruled out using additional laboratory analysis (including Lues serology and PCR testing for herpes simplex virus, cytomegalovirus, *Neisseria gonorrhoeae*, and *Haemophilus ducreyi*).

Source of infection

The patients were between 32 and 49 years old. None of them had travelled in an area endemic for LGV in the previous year. Three of the four patients had a simultaneous HIV infection. In two cases, regular contact in ‘dark-rooms’ in Hamburg appeared to be the likely source of infection; two men frequently changed sexual partners. It is interesting to note that all the strains and thus the infection sources were different. There could therefore be other undiagnosed patients.

Conclusions

If genito-anal or oral ulcerations are present, particularly in MSM and HIV infected patients, LGV should always be considered as a differential diagnosis.

Commentary

Between 1991-95, an annual average of 35 LGV infections were notified in Germany, whereas between 1996-2000 the annual average was seven cases. Only one case was reported from Hamburg during this time. Since the introduction of the 2001 Protection from Infection Act (Infektionsschutzgesetz), cases of LGV are no longer notifiable. Since October 2002, the Robert Koch Institut has conducted sentinel surveillance of sexually transmitted infections in Germany, but so far there have been no cases of LGV notified. The sporadic appearance of LGV cases were, until now, traced back to imported illnesses after travel to endemic areas.

At the beginning of this year, several MSM in the Netherlands were diagnosed with LGV [1]. Since then, over 30 cases of LGV have been diagnosed there. Many of these men reported a multitude of foreign sexual contacts, some of these in Germany. Sexual contact such as unprotected anal intercourse or ‘fisting’, took place mainly at sex parties, in ‘leather scene’ bars or saunas. In addition, at a network meeting of the European Surveillance of Sexually Transmitted Infections (ESSTI, funded by the European Commission DG SANCO [2]) in May 2004, outbreaks of LGV in

(ESSTI, funded by the European Commission DG SANCO [2]) in May 2004, outbreaks of LGV in MSM in Belgium and France (with 27 and 38 cases respectively) were reported. In Belgium, over 90% of the patients were also HIV positive.

Since LGV very rarely occurs in Germany and western Europe and if patients present with just ano-rectal symptoms or with an atypical clinical picture, it is likely that LGV is not considered as a diagnosis. It is therefore possible that cases in Europe are missed. Doctors treating and diagnosing HIV and other sexually transmitted infections should, if relevant symptoms are present, consider LGV as a differential diagnosis. Gastroenterologists should also consider LGV if there are notable signs in the rectum in patients who are MSM.

The above described sexual practices increase the possibility of co-transmission of other infections, such as syphilis and HIV, and so multiple infection should be always be ruled out.

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