1/5/05

TO: Sonoma County Medical Providers
FROM: Mary Maddux-Gonzalez, MD, MPH, Sonoma County Health Officer
SUBJECT: Public Health Alert

The California Department of Health Services (CDHS) STD Control Branch has requested that local health departments alert the medical community about the recent appearance of Lymphogranuloma Venereum (LGV) in California. **Lymphogranuloma venereum** was recently diagnosed in nine male patients in San Francisco. These are the first cases of LGV in San Francisco since 2001 and follow recent reports of a large outbreak (92 cases) of LGV among men who have sex with men (MSM) in the Netherlands, with additional cases in Belgium, France, Sweden, and Atlanta, GA. The Public Health Division is concerned about the possibility of cases in Sonoma County considering our proximity to San Francisco.

Given the ulcerative nature of this more invasive chlamydial infection with its presumed higher risk of facilitating HIV transmission, as well as the level of STD co-infection and the associated hepatitis C infection seen in the Netherlands outbreak, we are concerned about the potential adverse health effects. We will work with the Centers for Disease Control and Prevention (CDC) and the California STD Control Branch to assist clinicians in recognizing, diagnosing, managing, and reporting suspected cases of LGV, including

Related documents, including a clinical primer, management algorithm for suspected cases, and resources for diagnostic testing will be posted on the California STD/HIV Prevention Training Center (CA PTC) website at: **http://www.stdhivtraining.org/lgv/.**

Given what is known, the following are key points for providers:

PATIENT HISTORY

Providers 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.

SIGNS/SYMPTOMS

Clinicians who care for MSM should consider LGV in the diagnosis of compatible syndromes:

1) proctitis/protocolitis which can be hemorrhagic and associated with constitutional symptoms, or
2) tender inguinal lymphadenopathy associated occasionally with bubo formation and rarely with the presence of a painless genital ulcer.

TESTING
While testing for CT/LGV is important in all suspected cases, providers should exercise clinical judgment in initiating presumptive treatment for LGV. They should consider factors such as: severity of rectal symptoms in proctitis, presence of systemic symptoms that make LGV a more likely diagnosis, travel and exposure in Europe, and likelihood of follow-up.

If there is significant history and findings, clinicians should test to rule out *C. trachomatis* infections, including LGV. Two types of tests are available for the diagnosis of suspected LGV:

1) a serologic test (i.e. microimmunofluoresence (MIF) or complement fixation (CF))
2) a microbiologic test - either chlamydia tissue culture or Nucleic Acid Amplification Test (NAAT)) on rectal specimens or on specimens from bubo aspirates or ulcerative lesions in the presence of inguinal lymphadenopathy.

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.

For information on how to obtain and transport these specimens, please call Barbara Branagan (707) 565-4825 or Jim Stafford (707) 565-5162 or visit our website at www.sonoma-county.org/health/ph/providers

DIAGNOSIS AND REPORTING
A "Suspected LGV Case Report Form," available at **http://www.stdhivtraining.org/lgv/** should be completed. Suspected cases should be reported to Public Health by phone at (707) 565-4566 or by fax at (707) 565-4565.

Providers should report within 24 hours after the patient is seen, if the patient was presumptively treated. Otherwise, providers should report within 24 hours after the test results are available.

Laboratories should report within 24 hours after the test results are available.

Until we have a better understanding of the epidemiology and clinical features of this infection, we are defining a **suspected case** as any MSM with a compatible syndrome (i.e., proctitis or inguinal lymphadenopathy) and a positive lab test suggestive of a LGV infection (an MIF test with a titer of greater than 1:128 or a CF test with a titer of greater than or equal to 1:64) and/or a positive tissue culture or a NAAT test from a rectal specimen, bubo, or ulcer in the presence of lymphadenopathy.

TREATMENT

The recommended treatment for LGV is **oral doxycycline 100 mg bid x 21 days**. Though data is lacking, some experts suggest that azithromycin (1 gm orally in three weekly doses) is also effective in treating LGV.

PARTNER FOLLOW UP

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 bid x 7 days or a single 1-gram oral dose of azithromycin.

For assistance with partner follow up, you may call Alan Powell, Public Health Disease Intervention Specialist, at (707) 565-4827.

OTHER STDS

In patients with suspected LGV, screening is warranted for other STDs, especially urethral or urine NAAT for CT or gonorrhea (GC), rectal and pharyngeal GC, syphilis, and HIV.

Providers may submit these serologic and microbiologic specimens to the Public Health Laboratories at 3313 Chanate Road, Santa Rosa, CA (707) 565-4711.

QUESTIONS

Please call Dr. Leigh Hall at (707) 565-4599, Barbara Branagan, RN NP, STD Controller at (707) 565-4825; or Dr. Chris Hall at (510) 625-6006 or chall@dhs.ca.gov, if you have any questions or concerns.