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P 134
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This goes out to the underdog: how not to neglect sexually transmitted infections

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Background

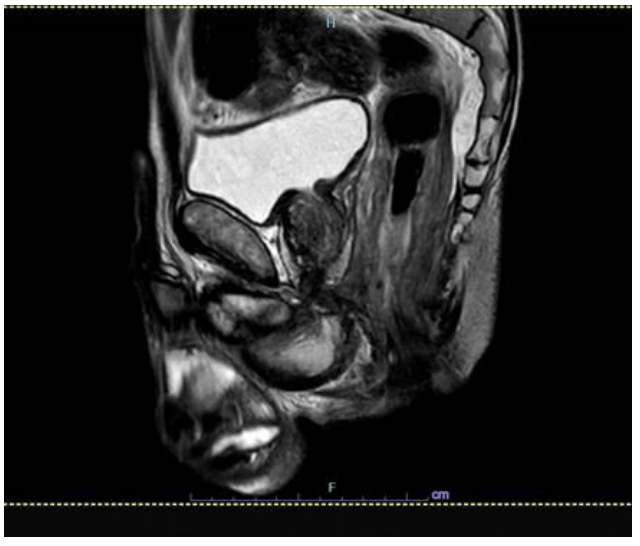
- Lymphogranuloma venereum (LGV) is caused by Chlamydia trachomatis invasive serovars (L1, L2, or L3). Over the past decade, LGV has emerged in Europe and North America as a leading cause of proctitis and proctocolitis in men who have sex with men (MSM).
- Rectal ulcerations, bleeding, mucoid discharge, tenesmus and pain are the primary clinical features.
- Prolonged infection can lead to the development of perirectal abscesses, strictures, fistulas, and systemic symptoms such as fever, malaise, weight loss and fatigue. Thus, the differential diagnosis regards mainly neoplasms and inflammatory bowel diseases.

Case presentation

- A 62-year-old man came to medical observation for anal pain poorly responsive to symptomatic therapy, and hemorrhagic rectal discharge. Weight loss was reported in the past few months.
- A Magnetic Resonance Imaging (MRI) showed a 7 centimeters-major diameter solid parietal lesion, with circumferential development in the mid-lower rectum, associated with regional lymphadenopathy – allegedly a secondary localization.
- Nonetheless, several endoscopic biopsies did not confirm the diagnosis of neoplasm, as they merely showed granulomatous tissue and abundant plasma cell infiltrate.
- However, the patient underwent derivative surgical treatment with colostomy creation. Intraoperative biopsies showed no evidence of neoplasm as well.
- An in-depth medical history revealed: previous syphilis and HCV infection; HBV-HDV coinfection; former drug addiction. Upon Infectious Disease consultation, a complete screening for sexually transmitted infections was performed: Chlamydia trachomatis NAAT was positive on rectal swab - while N. gonorrhoeae was negative.
- The analysis performed on the intraoperative specimens obtained the same results; on this basis, a 4 week-therapy with doxycycline was prescribed for LGV.
- Over one month, symptoms improved, with a reduction in tenesmus and anal discharge; test of cure on rectal swab was negative; a new MRI scan revealed a reduction in size of the rectal lesion. Eventually, the analysis on a bioptic sample obtained through another rectoscopy was negative for C. trachomatis, confirming disease resolution.

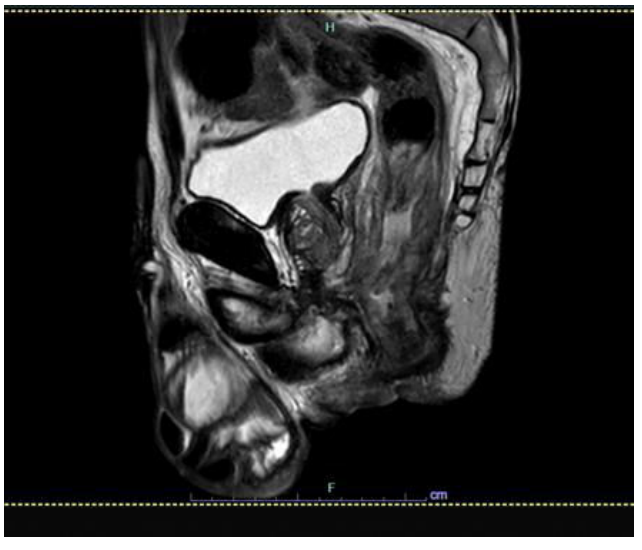
MRI #1a

Involvement of the rectum and anorectal junction; anal fistula. Collateral massive inguinal ernia was also present.



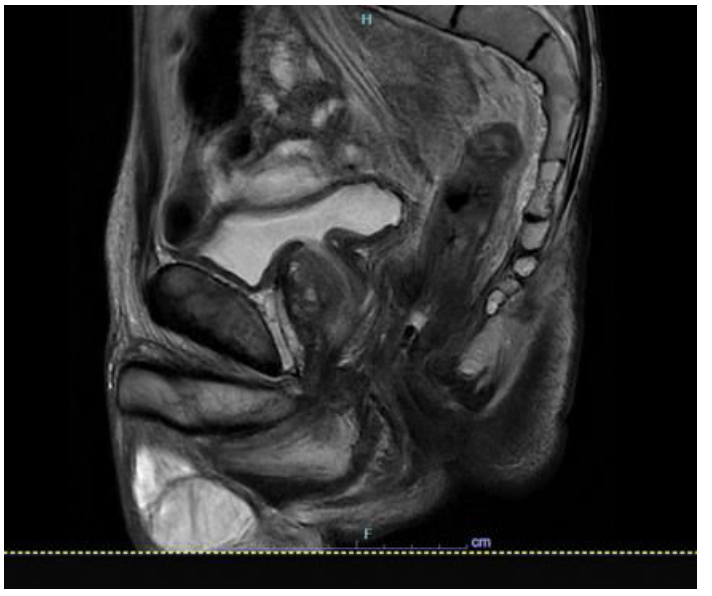
MRI #1b

More lateral scan showing edematous thickening of the mesorectal space, in which some lymph nodes can be seen. Furthermore, moderate effusion can be appreciated in the pelvic cavity.



MRI #2

Post-antibiotic treatment improvement: reduction of circumferen-tial rectal thickening; less oedema in the meso-rectal space. Patient had already undergone derivative surgical treatment with colostomy creation.



Discussion

- LGV still embodies an important cause of morbidity, especially among MSM.
- Physicians ought to maintain a high index of suspicion for LGV when assessing patients with proctitis or symptoms suggestive of inflammatory bowel disease.
- Such a challenging diagnosis also requires epidemiological information and the exclusion of other etiologies: definitive LGV diagnosis can only be pursued through LGV-specific molecular testing (e.g. PCR-based genotyping).

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