Lymphogranuloma Venereum (LGV)

Last updated: 18 September 2019

Public Health Priority:
Routine
PHU response time:
Enter cases on NCIMS within 5 working days of notification
Case management:
Responsibility of treating doctor
Contact management:
Responsibility of treating doctor
PHUs should assist if required

1. Reason for surveillance

To monitor the epidemiology of the disease and so inform prevention strategies.

2. Case definition

A confirmed case requires:

Isolation of Lymphogranuloma venereum (*Chlamydia trachomatis* serovars L1, L2 or L3)

OR

Detection of Lymphogranuloma venereum (*Chlamydia trachomatis* serovars L1, L2 or L3) by nucleic acid testing

3. Notification criteria and procedure

Lymphogranuloma venereum is to be notified by:

- Laboratories on diagnosis.

Only confirmed cases should be entered onto NCIMS.

4. The disease

Infectious agent
The bacterium *Chlamydia trachomatis* (serovars L1-3).

Mode of transmission
LGV is usually transmitted during sexual intercourse with an infected person. Rarely, the infection can also be transmitted from mother to baby during birth.

Timeline
The typical incubation period is variable, with a range of 3 to 30 days for a primary lesion. If a bubo is the first manifestation, the range is from 10 to 30 days up to several months. [1]

The period of communicability is variable and has not been well defined. [2].

Clinical presentation
The usual clinical presentation begins with a small painless lesion on the genital area or on an extra-genital site of inoculation [3], followed some weeks later by lymphadenopathy. Affected lymph nodes, which in males are usually inguinal and in females pelvic, may progress to fluctuant buboes. Proctitis may result from anal intercourse and is not usually accompanied by symptomatic lymphadenopathy. Inflammatory responses may result in systemic symptoms, including fever, chills, malaise and joint and muscle pains. Asymptomatic infections can also occur. [2]

5. Managing single notifications

Response time

Data entry
Within 5 working days of notification enter confirmed cases on NCIMS.

Response procedure
The response to a notification will normally be carried out in collaboration with the case's health carers. But regardless of who does the follow-up, PHU staff should ensure that action has been taken to:

- Confirm the onset date and symptoms of the illness
- Confirm results of relevant pathology tests
- Find out if the case or relevant care-giver has been told what the diagnosis is before beginning the interview
- Seek the doctor's permission to contact the case or relevant care-giver
- Review case and contact management
- Determine risk factors for infection

Cases under 16 years

- Where a case of LGV is reported in a child <16 years old, the PHU must send a letter to the doctor who requested the test to undertake an assessment of the risk of harm according to the mandatory reporting guidelines and obligations under the Children and Young Persons (Care and Protection) Act, 1998 and resources for clinical management (Therapeutic Guidelines).
- Where a case of LGV is reported in a child aged 12 years or under, the PHU must also directly contact the doctor (eg by telephone) to ensure that mandatory reporting obligations have been addressed. If no contact can be made, the PHU should contact the Child Well Being Unit (1300 480 420) or make a direct report to the Department of Community Services.
- The PHU should make reasonable attempts to record in NCIMS the Indigenous status of all cases under 16 years, for example by checking the LHD patient management system and/or calling the diagnosing doctor.
- All actions should be documented in the NCIMS record.

Case management

Investigation and treatment
In general, the attending medical practitioner is responsible for treatment. Specialist advice is usually required. Refer to Therapeutic Guidelines: Antibiotic.

Education
In general, the case's doctor provides education and counselling. The medical practitioner should provide information to the case about the nature of the infection and the mode of transmission.

Contact management

Identification of contacts
Sexual contacts in the 3 months before the first symptoms appeared, or since arrival from an endemic area. For asymptomatic cases, contact tracing should be undertaken for partners in the 6 months prior to diagnosis.

Investigation and treatment
The treating doctor is responsible for contact tracing. PHUs should work with Sexual Health Service staff to assist if requested. Contacts require counselling, examination, testing and presumptive treatment.

6. Managing special situations

Outbreak
Given that LGV is a rare disease in NSW, reports of several cases in an area may prompt public health action including an alert to GPs with relevant advice regarding clinical management and contact tracing. This should be done in collaboration with the Communicable Diseases Branch and local sexual health services.

6. References

[1] Gorwitz R, Papp J. Lymphogranuloma venereum. In Heyman DL (editor). Control of communicable diseases manual. American Public Health Association. 20th edition, 2015.
[2] de Vries HJC, de Barbeyrac B, de Vrieze NHN, Viset JD, White JA, Vall-Mayans M, Unemo M. 2019 European guideline on the management of lymphogranuloma venereum.
J Eur Acad Dermatol Venereol. 2019. 10.1111/jdv.15729.
[3] British Association for Sexual Health and HIV. BASHH Guidelines. Genital ulceration. LGV. 2013. Available from: https://www.bashhguidelines.org/current-guidelines/genital-ulceration/lgv-2013.