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Case Report

Lymphogranuloma venereum (LGV) proctocolitis mimicking rectal lymphoma

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ABSTRACT

Lymphogranuloma venereum is a sexually transmitted infection caused by serotypes L1-3 of *Chlamydia trachomatis* and may present as hemorrhagic proctocolitis. The diagnosis of an active infection is difficult to establish, as confirmatory testing can be unreliable or unavailable. Imaging findings can be nonspecific and mimic malignancy or other chronic infectious and inflammatory disorders. In this report, we present a case of lymphogranuloma venereum proctocolitis and its computed tomography features to highlight the relevant imaging findings and importance of timely diagnosis.

Introduction

Isolated proctitis usually presents with rectal urgency, tenesmus, dyschezia, and/or mucopurulent discharge. When inflammation spreads to the colon beyond the distal 10-12 cm, symptoms of colitis manifest, including abdominal pain or cramping, bloating, and diarrhea [1–3]. If inflammation is severe, it can lead to significant rectal wall thickening, masses, or lymphadenopathy. The differential diagnosis for proctocolitis includes infectious, inflammatory, ischemic, or neoplastic processes [1]. Lymphogranuloma venereum (LGV) is an uncommon cause of proctocolitis, and delay in diagnosis can lead to morbidity. The purpose of this case report is to increase radiologists' awareness of LGV and its imaging characteristics to aid in timely diagnosis and appropriate management.

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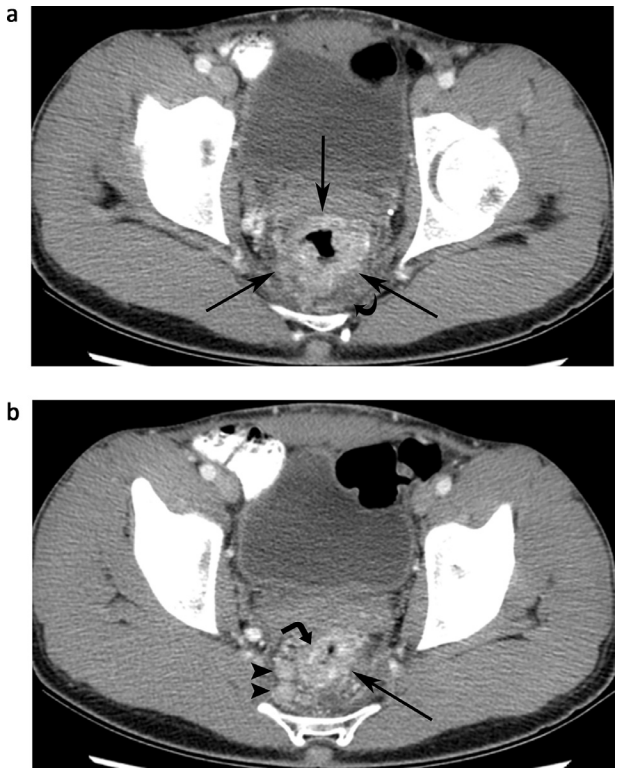

Fig. 1 – (A) Axial image from contrast-enhanced CT of the abdomen and pelvis at the level of the femoral heads demonstrating circumferential wall thickening of the rectum (black arrows) and perirectal fat stranding and induration (curved arrow). (B) Axial image of contrast-enhanced CT at the level of the low rectum demonstrating rectal wall thickening (black arrows), submucosal edema (right angle arrow) and right-sided perirectal lymphadenopathy (black arrow heads).

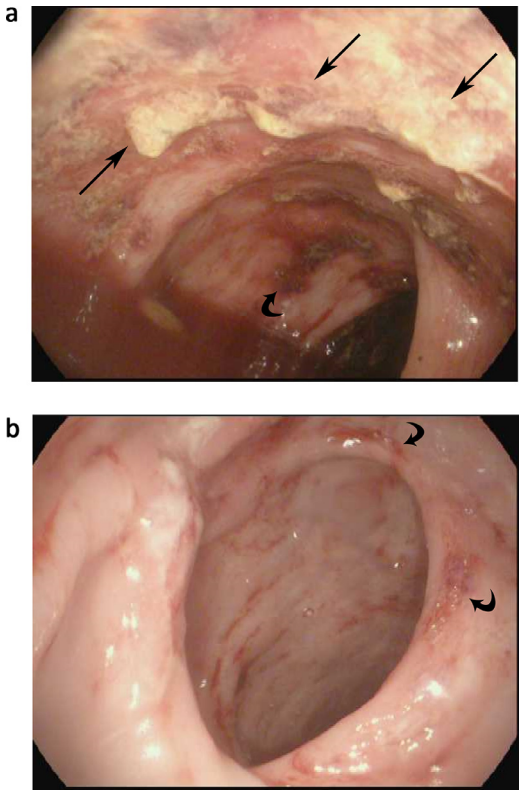

Fig. 2 – (A) Areas of discontinuous, ulcerated mucosa (arrows) with stigmata of bleeding (curved arrows) in the descending colon and (B) rectum.

Case report

A 23-year-old male presented with 1 day of profuse rectal bleeding. He reported 3 months of "blood streaked stool," 1 month of night sweats, and 1 week of dyschezia and tenesmus. He denied fevers, urinary symptoms, weight loss, joint pain, or rashes. He had presented to the emergency department 2 weeks earlier where a CT scan demonstrated irregular rectal wall thickening and multiple enlarged perirectal and left iliac lymph nodes (Fig. 1). He was told that these findings were "concerning for lymphoma," and urgent outpatient follow-up was arranged.

The patient's medical history was notable for human immunodeficiency virus (HIV) with poor medication adherence and low-grade anal dysplasia, for which he was previously lost to follow-up. He was known to be an asymptomatic chlamydia carrier without confirmed eradication and reported unprotected sexual intercourse with a male HIV-positive partner. He had no family history of colon cancer or inflammatory bowel disease (IBD).

On hospital admission, he was found to have a palpable, tender mass on rectal exam. Laboratory tests were notable for new anemia and serum positivity for HIV and syphilis. Tests for *Neisseria gonorrhoeae, Chlamydia trachomatis,* herpes simplex virus, fecal bacteria, and parasites were negative.

Given the concern for malignancy, a flexible sigmoidoscopy was performed which showed red blood as well as discontinuous areas of ulcerated mucosa from the rectum to the descending colon (Fig. 2). Microscopic examination revealed focal active colitis with superficial erosion. Immunohistochemistry for syphilis, cytomegalovirus, and adenovirus was negative. There was no chronicity to suggest a diagnosis of IBD. Given these findings and presumed bacterial etiology, empirical antibiotic treatment was initiated.

The patient experienced additional hematochezia, prompting a colonoscopy 5 days after the initial procedure. Rectal findings were substantially improved, notable only for mild proctitis with a single ulcer (Fig. 3). Biopsies of the rectum demonstrated acute colitis with ulceration. Endoscopic and histologic findings of the rest of the colon showed no evidence of active or chronic inflammation.

Given the rapid clinical, endoscopic, and histologic response to empirical therapy, the patient was diagnosed with stage II LGV and completed 21 days of antibiotic therapy. It was recommended that his partner be screened for sexually transmitted infections. In follow-up 2 months later, he was without