Lymphogranuloma Venereum (LGV)

Last updated: 1 September 2014

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:

- Demonstration of *Chlamydia trachomatis* sero vars L1 to L3 in fluid aspirated from a fluctuant bubo or from a genital lesion by immunoflourescence (IF), EIA, DNA probe, PCR, culture or by specific micro-IF serological tests.

Factors to be considered in case identification
Diagnosis is made by demonstration of C. trachomatis from bubonic fluid. Complement fixation testing is of diagnostic value if there is a four-fold rise or a single titre of >1:64.

3. Notification criteria and procedure

Lymphogranuloma venereum is to be notified by:

- Laboratories on diagnosis (ideal reporting by routine mail).

Only confirmed cases should be entered onto NCIMS.

4. The disease

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

Mode of transmission
Direct contact with open lesions of infected people, usually during sexual intercourse.

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

The period of communicability is variable, from weeks to years, during the presence of active lesions.

Clinical presentation
The usual clinical presentation begins with a small painless lesion on the genital area 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 rectal intercourse. Other symptoms which are usually present include fever, headache and joint pains.

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 30 days before the ulcer appeared or since arrival from an endemic area.

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, and culture and treatment of any lesion.

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.