

PostScript

LETTER

Lymphogranuloma venereum among men having sex with men; what have we learned so far?

Recently, French *et al* reported the first cases of lymphogranuloma venereum (LGV) in the United Kingdom.¹ One year later, the LGV outbreak first noticed in 2003 among men having sex with men (MSM) has spread beyond the first countries affected (Netherlands, Belgium, Germany, France, the United Kingdom, Sweden, and the United States) to other European countries like Spain, Italy, Switzerland, Poland, and outside the continent to Australia, United States, and Canada. Moreover, some of the questions raised in the publication of French *et al* can now be partially answered.

A retrospective study performed on anal swabs from STI clinic visitors in Amsterdam and San Francisco has taught us that the LGV strain which seems to be responsible for the current outbreak (L2b), can be traced back to at least 1981 in the United States and to 2000 in Europe.^{2,3} So it seems more appropriate to speak of a slow epidemic rather than an outbreak of LGV. What has caused LGV to spread unnoticed within the MSM community worldwide for many years? In part, this can be attributed to the routine chlamydia test procedures for MSM before 2003. Anal swabs positive for chlamydia were recorded as chlamydia proctitis. Since the occurrence of LGV outside the traditionally epidemic countries was unknown, additional testing for LGV was not performed.

Who should be screened for LGV? Most LGV patients reported unprotective sex and a history of multiple STIs. In a retrospective study we have tried to unravel other clinical and epidemiological criteria for LGV management in MSM.⁴ HIV status, proctoscopic findings, and results of Gram stained anorectal smears prove helpful in predicting LGV. LGV specific tests and syndromic treatment are recommended in MSM with anorectal chlamydia in combination with clinical signs of proctitis, HIV seropositivity or an elevated white blood cell count in Gram stained anorectal smears. Moreover, it appears that some of the LGV infections do not cause severe clinical symptoms. This may delay the diagnosis and hamper screening

and prevention measures. Götz *et al* described a group of 15 LGV patients of whom six seroconverted for hepatitis C (HCV) coinciding with the time they contracted LGV.⁵ It was speculated that sexual techniques that lead to mucosal damage, like fisting and use of sex toys, and a concomitant ulcerative STI, like LGV, facilitate the sexual transmission of HCV. Raised diagnostic problems can now be tackled more easily with a recently developed fast molecular biological diagnostic test (real time polymerase chain reaction) by our group, designed specifically for LGV *Chlamydia trachomatis* strains.⁶ This test can be performed under routine microbiological laboratory conditions and will hopefully facilitate the propagation of LGV screening programmes.

During the last International Society for Sexual Transmitted Disease Research meeting in July 2005 in Amsterdam, Netherlands, an LGV satellite workshop was organised under the supervision of the European Surveillance of Sexually Transmitted Infections (ESSTI) network in order to tackle urgent LGV related research questions in a multilateral joint effort (www.isstdr.nl/sat_meet.htm). Supranational collaborations will have to prove their benefit to increase our understanding of this LGV epidemic.

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CORRECTION

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There were several errors in the article by Aceijas C, Friedman, SR, Cooper HLF, *et al*. Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. *Sex Transm Infect* 2006;82(Suppl III):iii10–iii17.

In the abstract (lines 17–18), the sentence “Greater dispersion of national IDU prevalence was observed in Eastern Europe and Central Asia, and Asia & Pacific (IQR 1.91 and 1.47 respectively” should have been deleted. The last sentence of the results section (“Greater dispersion...Caribbean”) should also have been deleted.

Also in the abstract, the values of Q1 and Q3 for Eastern Europe and Central Asia are incorrect. They should have been as follows: Q1 0.39%; Q3 1.32%. The values of Q1 and Q3 for Asia and the Pacific should have been: Q1 0.14% and Q3 1.47%. The values of Q1 and Q3 for the Middle East and Africa should have been: Q1 0.11%; Q3 0.23%, and the values of the median and maximum Q1 and Q3 in Latin America and the Caribbean should have been 0.11%, 0.69%, 0.04% and 0.13%, respectively.

In the results section, the values of Q1 and Q3 for Eastern Europe and Central Asia are incorrect and should have been <0.39% and 1.32%. The values of Q1 and Q3 for Asia and the Pacific should have been ≤0.14% and <1.47%. The values of Q1 and Q3 for the Middle East and Africa should have been 0.11% and ≤0.23%, and the values of the median, maximum, Q1 and Q3 in Latin America and the Caribbean should have been ≤0.11%, 0.69%, ≤0.04% and ≤0.13%, respectively.