or because of known analgesic effects. In the small sample studied by Lee *et al*, baseline assessment did not detect significant depression; how effective treatment would be in a larger, more representative, group of patients with CPPS—in whom depression may be a more prominent feature—remains to be determined. Recruitment into adequately powered trials is likely to require a multicentre collaboration.

For many men, time, rather than current treatments, may have the greatest influence on symptoms, with around one third reporting resolution of symptoms after 1 year.[30] Overall management of CPPS (investigation and treatment) remains highly variable,[31] and access to the most appropriate therapists (including pain experts, psychotherapists and, possibly, psychosexual therapists and physiotherapists) is often inadequate. The extent to which genitourinary medicine clinics can develop services for chronic conditions (other than HIV) may be limited by the strengthened focus on sexually acquired infections driven by epidemiological trends and the national sexual health strategy. At this point, the future for improving service provision for men with this often distressing and disabling condition seems very uncertain.

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LYMPHOGRANULOMA VENEREUM

Lymphogranuloma venereum in the United Kingdom

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First cases reported from enhanced surveillance

Until 2003 lymphogranuloma venereum (LGV), a disease caused by the more invasive L serovars of *Chlamydia trachomatis*, was considered a rare disease outside resource poor countries. Since then it has emerged as a significant problem among men who have sex with men (MSM) in Europe. In 2003 an outbreak of LGV was recognised in Rotterdam in the Netherlands.[1] More than 100 men have been reported in this outbreak, most of whom were HIV positive and many had concomitant sexually transmitted infections including hepatitis C infection. Although many reported unprotected anal sex as a risk factor for acquisition of LGV, fisting and the sharing of sex toys also appeared as possible routes of transmission. Almost all presented with proctitis and symptoms included rectal pain, discharge, tenesmus, and other signs of lower gastrointestinal inflammation including constipation and abdominal pain. Some reported systemic symptoms such as fever and malaise. Genital and inguinal symptoms were rare with only one patient presenting with inguinal lymphadenopathy.

Since that report similar outbreaks have been recognised in Antwerp, Hamburg, and Paris.[2–4] Cases have also been reported from Sweden and more recently from the United States (New York, San Francisco, and Atlanta).[5] All

the reported cases have been caused by the L2 serovar, although there is some evidence that a number of genetically distinct strains of *C trachomatis* L2 are responsible for these outbreaks.[6]

In October 2004 the Health Protection Agency (HPA) sent out an alert to genitourinary medicine (GUM) clinicians in England and established a case definition, reference service, and reporting system for LGV.[7] In addition to the information produced by the HPA, the Terence Higgins Trust produced briefings for use in clinics and a leaflet for use in gay venues to increase awareness. The case definition used by the HPA is confirmation of *C trachomatis* and presence of an LGV serovar, L1, L2, or L3, by genotyping. The HPA reference service will test rectal specimens from patients with anorectal symptoms (typically proctitis, rectal discharge) or urethral specimens from patients with inguinal lymphadenopathy that are known to be positive for *C trachomatis*. Serology for *C trachomatis* has been used in Europe and can suggest the possibility of LGV, but does not confirm cases because of a lack of specificity, and has not been used in England as part of the case definition (www.hpa.org.uk/infections/topics_az/hiv_and_sti/LGV/lgv.htm).

In January 2005 the first 24 cases of LGV were reported in the United Kingdom,[8 9] most from London clinics. Enhanced surveillance data were available for 19 cases and confirmed a picture similar to that reported in the rest of Europe. All were MSM, 17 were HIV positive, four also had hepatitis C infection, and most had symptoms suggesting LGV. Fifteen patients reported a probable country of infection; five in mainland Europe and 10 in the United Kingdom. Up to the middle of February 2005 a total of 34 cases of LGV have been reported in the United Kingdom.

LGV presenting as proctitis in homosexual men is well recognised.[10] The primary (papule/ulcer) of LGV frequently goes unnoticed and patients often present with acute haemorrhagic proctitis and may have pronounced systemic symptoms such as fever and weight loss. Proctoscopy often reveals marked proctitis, which is usually confined to the distal 10 cm of the anorectal canal. Left untreated, chronic inflammation may lead to stricture and fistula formation as well as local lymphatic obstruction and lymphoedema.[11] Patients with acute proctitis related to LGV usually respond well to antibiotic therapy. At present the recommended treatment for LGV in the United Kingdom is either oral doxycycline 100 mg twice daily, or oral erythromycin 500 mg four times a day, both regimens given for 3 weeks.[12] Patients with chronic infection including abscess, fistulas, and strictures often require surgical intervention.

It is likely that LGV has been present for some time in MSM in the United Kingdom, with many cases going undiagnosed. The first UK case identified so far is from a retrospective sample dating from January 2004. The epidemiology and clinical features of LGV in MSM are not fully understood; it is likely that some undiagnosed cases will have progressed to invasive disease, while others may yet prove to be asymptomatic. Clearly, further collaborative research is required.

The first steps in understanding and controlling this outbreak are to increase community and clinician awareness of LGV, to further develop our surveillance system and to monitor clinical manifestations. A national incident team has been established to oversee responses with the aim of developing effective control measures for this outbreak. The key challenge will be to identify and implement appropriate health promotion and prevention measures, particularly addressing the sexual health needs of HIV positive homosexual men, and ensure that potentially severe sequelae of untreated LGV are minimised.

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A national LGV incident group has been established by the HPA in collaboration with the British Society for Sexual Health and HIV (BASHH), the Terence Higgins Trust (THT), and the Society for Sexual Health Advisers (SHAA) and is chaired by Helen Ward (helen.ward@hpa.org.uk).
Leaflet produced by Terence Higgins Trust. (Single copies can be obtained through THT Direct 0845 12 21 200; multiple copies by emailing james.glavin@tht.org.uk).

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