

Case Report

LYMPHOGRANULOMA IN PREGNANCY: A RARE CO INCIDENCE

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ABSTRACT

Lymphogranuloma Venerum is a sexually transmitted disease. Its coincidence with pregnancy is extremely rare. We report such a case where the patient was unbooked and came with pre term labour pains.

Keywords: Lymphogranuloma, Pregnancy

INTRODUCTION

Lymphogranuloma venereum (LGV) is a sexually transmitted infection (STI) caused by *Chlamydia trachomatis* serotypes L1, L2 and L3. Unlike serotypes A-K, LGV serotypes are invasive (Heaton *et al.*, 1988). Whenever infectious disease occurs in a gravid patient, an understanding of the effect of the disease on the fetus and process of parturition, effect of pregnancy on the disease and transmission to the fetus has to be critically studied (Wilson and Hesseltime, 1942). LGV is transmitted through sexual relations (oral, anal or vaginal) involving contact with a mucous membrane (anus, rectum, glans, vagina, mouth or throat) infected with LGV, with or without visible lesions or infected discharge or secretions from the penis, anus or vagina. A pregnant woman infected with LGV can transmit the infection to her newborn during childbirth, when the baby passes through the vagina. A person who has infected but is not treated can transmit LGV for several weeks or even months after contracting it.

CASES

A 29 year old female, G3P2L1D1 reported to us with 35 weeks pregnancy. She was unbooked and uninvestigated in the ante-natal period. Patient was in preterm labour. On local examination she had swelling of both the labia minora. The swelling was present since 6 weeks. The swelling started with a small ulcer on the labia of both sides. She also had enlarged inguinal lymph nodes. The patient was investigated on the lines of sexually transmitted disease. She tested positive for IgM antibodies for *Chlamydia trachomatis*, with titres more than 1:256. No other features of the infection were present like the rectal strictures. All other tests of STD s were negative. Patient had history of a preterm birth with early neonatal death. Emergency Caesarian section was done as the vulva was distorted and also because of non reassuring fetal heart rate. She was prescribed injectable antibiotics in post operative period. Later on, she was prescribed Erythromycin (without Estolate formulation). Patient was kept on regular follow up in post natal period and became seronegative.

DISCUSSION

LGV is commonly divided into three stages (Lambert and Elizabeth, 2006):

Primary LGV

- The incubation period is 3 to 30 days.
- One or several small painless papules at site of inoculation (vagina, penis, rectum, sometimes cervix, but also in the mouth and pharynx following exposure through fellatio or cunnilingus); they may ulcerate.
- Primary lesions resolve spontaneously and can easily go unnoticed.

Secondary LGV

- Secondary LGV begins within two to six weeks (sometimes 4 to 6 months) of primary lesion.
- Often accompanied by systemic symptoms such as low-grade fever, chills, malaise, myalgias, arthralgias; occasionally by arthritis, pneumonitis or hepatitis/perihepatitis; rarely cardiac lesions, aseptic meningitis or ocular inflammatory lesions .

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- ☐ Abscesses and draining fistula are possible (fewer than one out of three patients).
- ☐ Involves lymph nodes or the anus and rectum

Tertiary LGV (chronic, untreated)

Most patients recover spontaneously with no lasting effects following the secondary stages. However, some patients develop the following complications one, two or several years after disease onset:

- ☐ Chronic inflammatory lesions leading to scarring and fibrosis:
- ☐ Lymphatic obstruction causing genital elephantiasis;
- ☐ Rectal strictures and fistulae;
- ☐ Significant destruction of genitalia (esthiomene).

The diagnosis of the disease is made by culture and nucleic acid amplification tests. Serology tests are also useful which includes micro immunofloresence and compliment fixation tests.

The first line of treatment is with Doxycycline, Erythromycin as alternative and Azithromycin as a possible treatment (Lambert and Elizabeth, 2006). Patients with LGV should be followed until tests are negative (test of cure). Surgery may be required to repair genital/rectal lesions caused by tertiary LGV.

Due to limited literature available on LGV in pregnancy, further studies are required.

Conflicts of Interests: none

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