

## Rectal lymphogranuloma venereum mimicking cancer

A 63-year-old man with history of acquired immune deficiency syndrome (AIDS), intravenous drug use, and recent anaphylaxis complicated by acute kidney injury presented with nausea, vomiting, constipation, rectal bleeding, and abdominal pain for 3 days. Laboratory findings included a CD4 count of 104/mm<sup>3</sup>, anemia with hemoglobin of 10.9 g/dL and hematocrit of 31.7%, elevated blood urea nitrogen (42 mg/dL) and creatinine (2.05 mg/dL), hyperphosphatemia (11.3 mg/dL), and hypocalcemia (7.8 mg/dL). Microbiology studies including cytomegalovirus polymerase chain reaction (PCR), *Clostridium difficile* toxin, tissue and blood cultures as well as stool ova and parasites were negative. A computed tomography (CT) scan revealed dilation from the rectum to the ascending colon up to 8.9 cm. The patient was started on oral calcium acetate for hyperphosphatemia.

A colonoscopy was remarkable for two broad-based rectal nodules, ranging in size from 1.5 cm to 2 cm (● Fig. 1 a, b) in addition to a stricture immediately proximal to the nodules (● Fig. 1 c). The findings were concerning for malignancy, and multiple biopsies were carried out, revealing nonspecific regenerative changes and erosions (● Fig. 1 d), and mass-forming calcifications (● Fig. 1 e) that were positive for Von Kossa stain (● Fig. 1 f), possibly due to inflammation or calcium acetate pills. Colonoscopic dilation was carried out, and IgM to *Chlamydia* was positive. Doxycycline was initiated and oral calcium acetate was discontinued due to intramucosal calcifications. The clinical picture presented here is that of rectal lymphogranuloma venereum (LGV), an uncommon sexually transmitted disease caused by the intracellular bacteria *Chlamydia trachomatis*. Symptoms include proctocolitis, pain, diarrhea,

discharge, and anorectal inflammation with associated rectal strictures [1]. Findings on pathology include lymphoplasmacytic inflammation. Serology for *Chlamydia* has approximate sensitivities and specificities of 80% [2]. Culture is difficult, and swabs of infected areas may be analyzed via PCR, which is the current gold standard. LGV should be kept in mind as a cause of benign rectal stricture.

Endoscopy\_UCTN\_Code\_CCL\_1AD\_2AJ

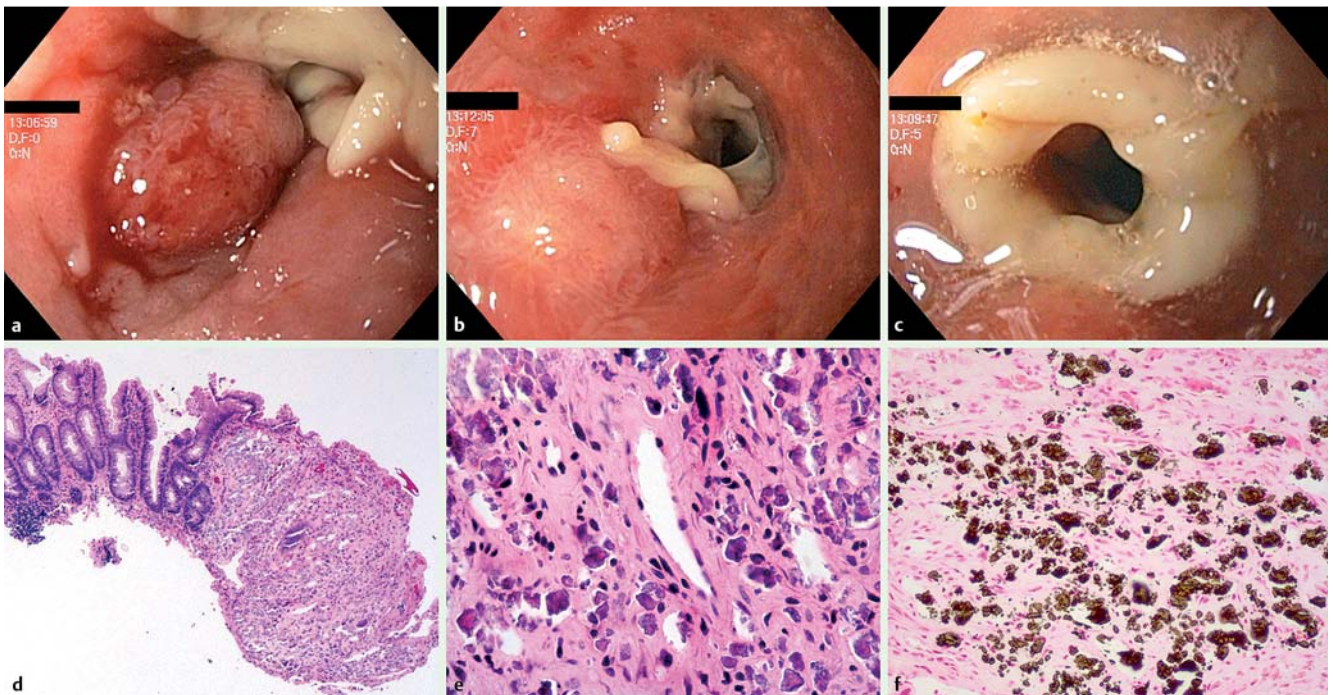
Competing interests: None

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**Fig. 1** Colonoscopic and histologic findings in a 63-year-old man with AIDS and recent anaphylaxis complicated by acute kidney injury. Colonoscopy was significant for two broad-based rectal nodules (a, b) as well as a tight stricture (c) with associated purulent exudate. Microscopically, there are signs of chronic inflammation of the mucosa (d) as well as mucosal calcifications (e) positive for Von Kossa calcium stain (f).

**References**

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**Bibliography**

**DOI** <http://dx.doi.org/10.1055/s-0033-1344407>  
Endoscopy 2013; 45: E315–E316  
© Georg Thieme Verlag KG  
Stuttgart · New York  
ISSN 0013-726X

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