A 21-year-old Male With Bloody Diarrhea & Purulent Rectal Drainage

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Case presentation

- **A 21-year-old male was admitted to the hospital after presenting with 21 days of rectal bleeding, diarrhea, purulent rectal drainage, and tenesmus.**
- **He complained of bloody and mucoid stools.**
- **He did not have rectal bleeding prior to this illness.**
- **He reported no skin lesions of his genital or anal areas.**

Case presentation

- He had not been eating or drinking well during the course of this illness due to lack of appetite.
- Associated symptoms included a 15 Kg weight loss Within 3 months
- He denied any abdominal pain, fevers, night sweats, oral lesions, or arthralgia.
- He was started on Mesalazine 8 days ago, according to an internal medicine specialist with a possible diagnosis of inflammatory bowel disease (Without further evaluation and colonoscopy)! !
- Past medical history included one episode of candidal esophagitis (4 weeks ago) that was successfully treated with fluconazole.

Case presentation

- Social history was significant for oral and receptive anal intercourse on multiple occasions, with last sexual encounter within the past month.
- Condom use was inconsistent.

- He denied knowledge of his partner having any sexually transmitted infections.
- He denied personal history of sexually transmitted infections or sexual abuse.

Case Presentation
PH/EX

Upon admission, physical exam showed an alert and cooperative male/ Apyretic /Stable Vital sign

Skin examination: normal, no rash or skin lesions on the trunk or limbs

External rectal exam :tenderness and erythema around the perianal region as well as a single anal fissure at the 2 o'clock position.
No perianal cutaneous lesions.

Genitourinary exam: normal , without urethral Discharge . No genitourinary cutaneous lesions were present.

Cardiopulmonary, abdominal and neurological, examinations were all normal.

Laboratory evaluation

- **CBC:**
- **WBC=2100 (Lymph:10%)**
- **HGB= 10**
- **PLT=106000**
- **Stool exam: inflammatory pattern**
- **ESR:18**
- **CRP: 7**

- **LFT: NL**
- **Neisseria gonorrhoeae and Chlamydia trachomatis PCR from rectal swab and urine: neg**
- **Serum VDRL: neg**
- **HIV Ab: ?**
- **HCV Ab: neg**
- **HBS Ag: neg , HBS Ab: 2, HBC Ab:neg**

Case presentation
PH/EX

To assess for IBD and other etiologies of symptoms
were perfo

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  signs of candidiasis.
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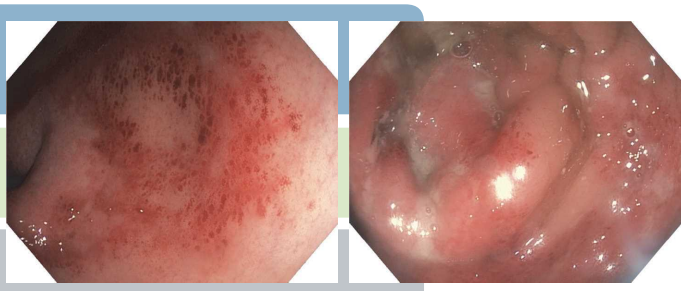
  More proximal portions of the colon were not affected.



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(b) Additional ulcerated lesions and mucopurulent exudates are present.

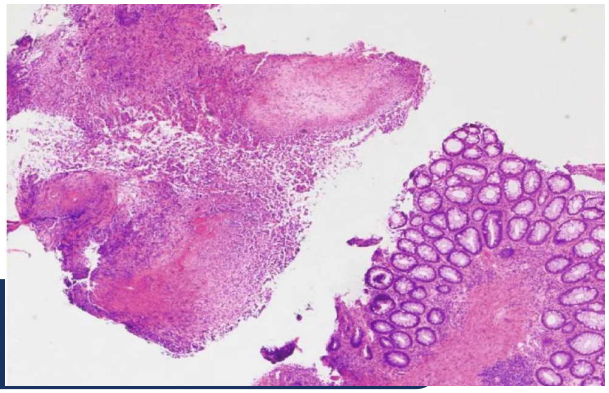
Patient Process

Rectal biopsies were obtained and sent for Pathology & N. gonorrhoeae and C. trachomatis, CMV PCR, which were negative, and PCR positive for herpes simplex virus (HSV).

Microscopic examination of the biopsy specimen was <u>without</u> histopathological findings concerning for IBD.

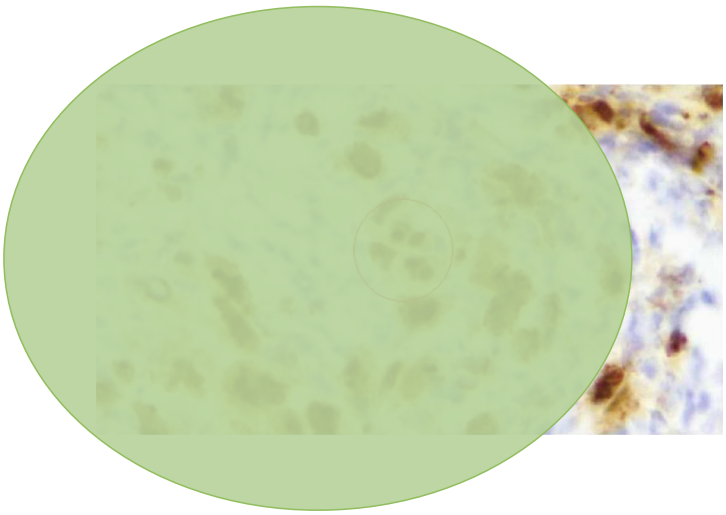
Patient Process

- On hematoxylin and eosin (H&E) slides, the rectal biopsy was primarily composed of granulation tissue suggestive of ulceration, with extensive necrosis and acute inflammatory exudate.
- The rectal mucosa present had reactive epithelial changes in a background of mucosal prolapse.



Patient Process

HSV immunohistochemical stain (IHC) highlighted viral inclusions within endothelial cell and fibroblast nuclei. CMV IHC was negative



Patient Process

- **At this time, the patient's HIV test was reported as reactive.**
- **Then confirmatory tests were performed.**

Patient Process

- **The patient was prescribed Acyclovir.**
- **Following treatment for 10 days, the patient's symptoms resolved.**

➢ **Primary Care of HIV**

➢ **Antiretroviral treatment started.**

Discussion

DISCUSSION

- Proctitis is an inflammatory process of the lining of the distal colon and rectum.
- Symptoms of proctitis include anorectal pain, tenesmus, mucopurulent exudates, and hematochezia.
- Infectious proctitis must be considered prior to immunosuppressant therapy for presumed IBD, as immunosuppressant medications may result in a lack of improvement or clinical worsening of infectious proctitis.
- In males who have sex with males (MSM) and others who engage in receptive anal intercourse, sexually transmitted infections must be considered.

DISCUSSION

Risk factors for proctitis

- **HIV seropositive**

2021 European Guideline on the management of proctitis

SEXUALLY TRANSMITTED CAUSES OF PROCTITIS

Table 1 Sexually associated causes of proctitis, proctocolitis and enteritis†

Causes of distal proctitis	Causes of proctocolitis	Causes of enteritis
Neisseria gonorrhoeae	*Shigella* spp.	*Giardia lamblia*, *Cryptosporidium* spp.
Chlamydia trachomatis:	*Campylobacter* spp.	Microsporidia§
Genotypes D-K	*Salmonella* spp.	Hepatitis A virus
Genotypes L_{1-3} (LGV)	*Escherichia coli*	
Treponema pallidum	*Entamoeba histolytica*	
Herpes simplex virus	*Cryptosporidium* spp.	
Mycoplasma genitalium ‡	Cytomegalovirus§	
Traumatic (sex toys, douching)	Intestinal spirochetosis¶	

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include N
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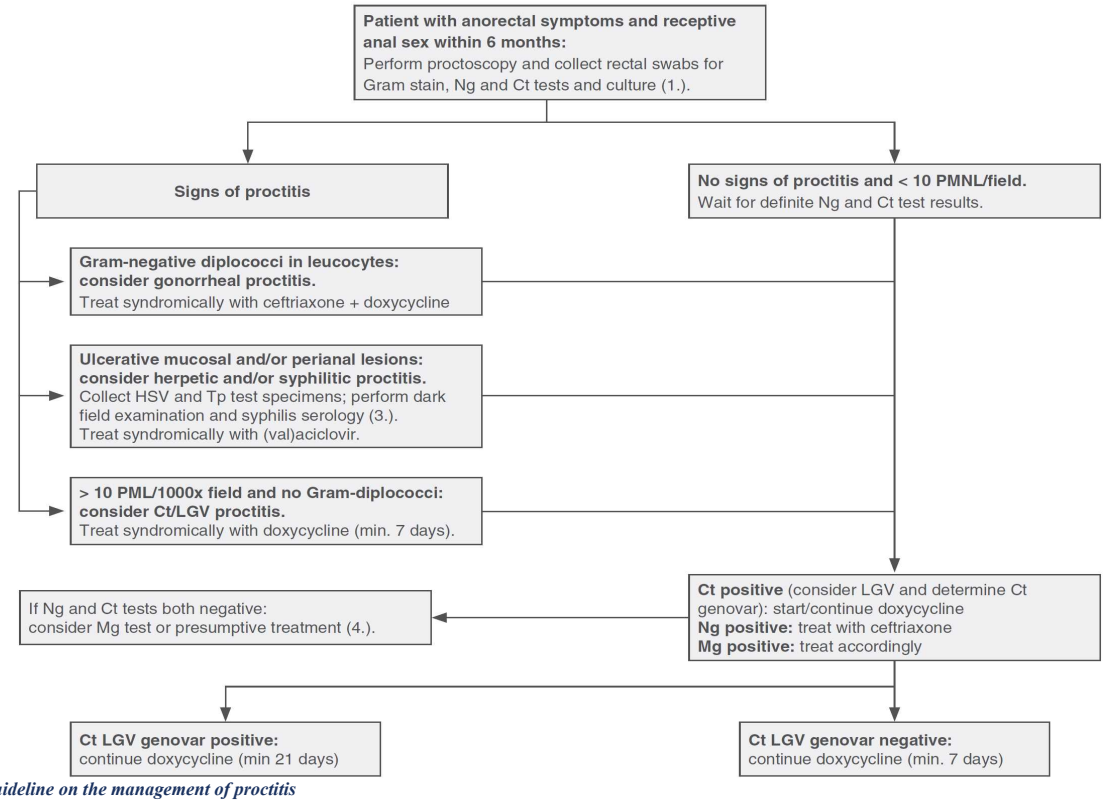
especially in HIV infected patients.

2021 European Guideline on the management of proctitis

DISCUSSION

- **Patients presenting with acute proctitis should receive anoscopy and be evaluated for infection with testing for HSV, N. gonorrhoeae, C. trachomatis, T. pallidum, and HIV.**



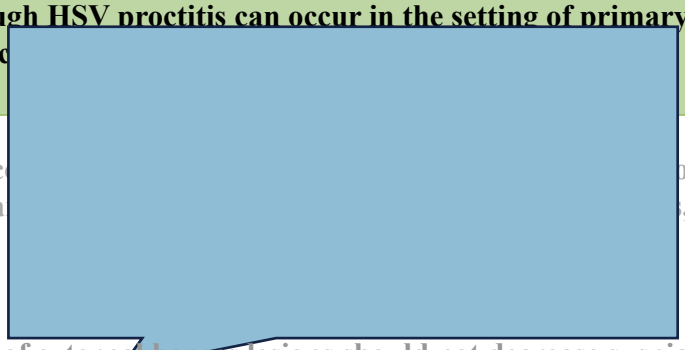
2021 European Guideline on the management of proctitis

HSV PROCTITIS

- **In addition to symptoms of infectious proctitis listed above, HSV proctitis can present with constipation, sacral paresthesia, and difficulty urinating, possibly related to autonomic nervous system dysfunction associated with the neurotropic nature of HSV .**
- **These symptoms of HSV proctitis usually begin after an incubation period of 2–12 days . HSV proctitis can be caused by HSV-1 or HSV-2, but approximately 70% of cases are caused by HSV-2.**

HSV PROCTITIS

Though HSV proctitis can occur in the setting of primary infec



- Endosc of the colon a , and
- **Absence of external herpes lesions should not decrease suspicion for HSV proctitis, as only ~30%of men with herpes proctitis have external lesions at the time of diagnosis.**

HSV PROCTITIS

MSM and HIV-positive individuals are at higher risk of HSV proctitis.

Compared to the seroprevalence of HSV-1 and HSV-2 of 57.7% and 17.0%, respectively, in the general population of the United States , the seroprevalence in MSM is significantly higher.

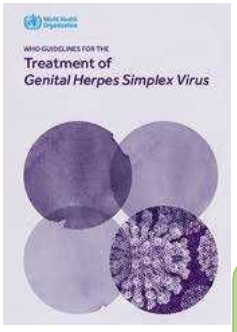
95% of MSM are seropositive for HSV-1, HSV-2, or both.

HSV PROCTITIS

- **HIV-positive individuals have increased symptomatic and asymptomatic shedding of HSV (especially when CD4 counts are low), increasing risk of transmission to sexual partners.**
- **HSV also has implications in regard to transmission of HIV.**
- **Symptomatic and asymptomatic HSV have been shown to increase HIV shedding, and those with rectal mucosal inflammation and ulceration associated with HSV likely have increased susceptibility to HIV infection due to the nonintact nature of the mucosal barrier .**

HSV PROCTITIS

Given the relationship between HSV and HIV, it is important that all patients who present with HSV proctitis, be screened for



FIRST-LINE TREATMENT OF HSV PROCTITIS

- **CDC recommend antivira**
  HSV infection is suspecte
  in acute proctitis.

Recommended Regimens for First Clinic
Herpes*

Acyclovir† 400 mg orally 3 times/day for 7–10 d
or
Famciclovir 250 mg orally 3 times/day for 7–10 days
or
Valacyclovir 1 g orally 2 times/day for 7–10 days

* Treatment can be extended if healing is incomplete after 10 days of therapy.
† Acyclovir 200 mg orally 5 times/day is also effective but is not recommended because of the frequency of dosing.

RECOMMENDED REGIMENS FOR **EPISODIC THERAPY** FOR RECURRENT HSV-2 GENITAL HERPES

Recommended Regimens for Episodic Therapy for Recurrent HSV-2 Genital Herpes*
Acyclovir 800 mg orally 2 times/day for 5 days
or
Acyclovir 800 mg orally 3 times/day for 2 days
or
Famciclovir 1 g orally 2 times/day for 1 day
or
Famciclovir 500 mg orally once, followed by 250 mg 2 times/day for 2 days
or
Famciclovir 125 mg orally 2 times/day for 5 days
or
Valacyclovir 500 mg orally 2 times/day for 3 days
or
Valacyclovir 1 g orally once daily for 5 days

* Acyclovir 400 mg orally 3 times/day for 5 days is also effective but is not recommended because of frequency of dosing.

SUPPRESSIVE THERAPY FOR RECURRENT HSV-2 GENITAL HERPES

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Acyclovir 4
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Valacyclov
or
Famciclovi

* Valacyclovir 500 mg once a day might be less effective than other valacyclovir or acyclovir dosing regimens for persons who have frequent recurrences (i.e., ≥10 episodes/year).

KEY MESSAGES

Infectious proctitis must be considered prior to immunosuppressant therapy for presumed IBD, and immunosuppressant medications.

In males who have sex with males (MSM) and others who engage in receptive anal intercourse, sexually transmitted infections must be considered.

Absence of external herpes lesions should not decrease suspicion for HSV proctitis.

Given the relationship between HSV and HIV, it is important that all patients who present with HSV proctitis, be screened for HIV.

Any questions?