Genotyping *Chlamydia trachomatis* strains among men who have sex with men from a Northern Spain region: a cohort study

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**ABSTRACT**

**Objectives:** To determine the prevalence of anorectal *Chlamydia trachomatis* serovars in a group of men who have sex with men (MSM) with high risk sexual behaviour, attendees at a sexually transmitted infection (STI) unit from a region in Northwest Spain.

**Design:** Retrospective and descriptive study of all swabs obtained from all MSM attendees at an STI unit, from 2007 to 2011. Retrospective ethical approval was granted by the Ethical Regional Committee of Clinical Investigation of the Principality of Asturias.

**Setting:** The STI clinic in Oviedo, Spain, offers screening and free-of-charge treatment to about 3646 patients per year.

**Participants:** 303 symptomatic and asymptomatic consecutive and unselected MSM patients (mean age 36.7 and range 21–55 years) were evaluated for anorectal chlamydial infection.

**Main outcome measures:** *C trachomatis* DNA extraction and detection in all rectal and in 36 urethral swabs. Characterisation of *Chlamydia trachomatis* genotypes through sequencing of ompA gene amplicons and further phylogenetic tree analysis.

**Results:** We found 40 (13.2%) positive rectal samples. The distribution of genotypes was E (37.5%) followed by G (25%), D (12.5%), J (10%) and L2b (5%). 25 (62.5%, 95% CI 46.2 to 78.7) of the *Chlamydia*-infected MSM showed clinical manifestations while 15 (37.5%, 95% CI 21.25 to 53.75) reported no symptoms. Concurrent infection with other STIs was documented in 27 (67.5%, 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients. The most frequently reported clinical symptom was anal ulcer (7 cases, 17.5%; 95% CI 51.7 to 83.2) patients.

**Conclusions:** The first two confirmed cases of lymphogranuloma venereum (LGV) in MSM in Asturias are reported, probably indicating the increase of this infection. The Spanish *C trachomatis* laboratory-based surveillance system may underlie an underestimated number of chlamydial infections. Whenever mild and atypical symptoms exist, laboratory evaluation would contribute to the early implementation of appropriate therapy and prevent LGV dissemination.

**INTRODUCTION**

*Chlamydia trachomatis* is an important human pathogen that causes a spectrum of clinically significant diseases. According to the Centers...
for Disease Control and Prevention (CDC), 92 million infections with *C. trachomatis* are detected globally each year. On the basis of disease manifestation, serovars A, B, Ba and C cause trachoma; serovars D–K are associated with urogenital infections and serovars L1–L3 are responsible for lymphogranuloma venereum (LGV). The L2 serovar can be further separated into different genetic variants according to the amino acid differences in the *ompA* gene. The L2b–L2e genovariants are associated with the development of proctitis in men who have sex with men (MSM). LGV was considered as a sporadic infection in developed countries, occurring endemicly only in parts of Africa, Latin America and Asia. At the end of 2003, there was an outbreak of LGV in MSM in the Netherlands, indicating the emergence of a new epidemic in this high-risk group. However, few cases of this infection have been reported in the North of Spain, with the exception of Barcelona, where a large number of cases have been notified since 2007.

**MATERIALS AND METHODS**

**Patients and clinical samples**

A total of 339 biological samples (303 rectal and 36 urethral Dacron swabs) were tested for *C. trachomatis* by the Cobas Taqmam CT system according to the manufacturer’s instructions (Roche Diagnostic Systems, Branchburg, New Jersey, USA). These specimens were collected between January 2007 and November 2011 from 303 symptomatic and asymptomatic consecutive and unselected MSM (mean age was 36.7 (range 21–55)) attending the STI unit of the Hospital Monte Naranco, Oviedo, Spain, where STI screening and free-of-charge treatment are provided (about 3646 patients per year). Positive *C. trachomatis* specimens were kept at −70°C in sucrose-phosphate (2SP) medium until retrospective *ompA* genotyping. All patients had promiscuous behaviour with various sexual partners, and one of them was engaged in prostitution. Three sexual partners include the study group. Three hundred were Spaniards with residence in Spain (297), the Netherlands (2) and the USA (1). Two men were Brazilians and one Moroccan. HIV, hepatitis B virus (HBV), hepatitis C virus, gonorrhoea and syphilis infections are routinely evaluated at the STI clinical unit and were made available to the present evaluation team. Retrospective ethical approval was granted by the Ethical Committee of Clinical Investigation of the Principality of Asturias.

**Genotyping**

*C. trachomatis* DNA was extracted using the NucliSSENS easyMag system (bioMerièux, Marcy l’Etoile, France). To genotype *C. trachomatis* specimens, a 990 pb fragment of the *ompA* gene was amplified according to a nested-PCR methodology described earlier. PCR-amplified *OmpA* gene fragments were purified from agarose gels by using the Montage DNA Gel Extraction Kit (Millipore, Bedford, Massachusetts, USA) and sequenced with the BigDye Terminator Cycle Sequencing Kit (Applied Biosystems, Foster City, California, USA) using inner primers (MOMP87-RVS1059).

The amplicon sequences were aligned to analogous sequences from reference strains of each genotype by using the ClustalW2 program. The strains were A/Sal (accession number M58938), B/TW-5 (M17342), B/1U-1226 (AF063208), C/TW3 (M17343), D/B-120 (X62918), D/IC-Ca8 (X62920), E/Bour (X52557), F/IC-Cal3 (X52080), G/UW57 (AF063199), H/UW4 (X16007), I/UW-12 (AF063200), Ja/IU-4168 (AF063201), J/UW36 (AF063202), Ja/IA-795 (AF063203), K/UW31 (AF063204), L1/440 (M65533), L2/434 (M14738), L2b/144276 (DQ217607), L3/404 (X55700) and *Chlamydia muridarum* MoPnT (M64171), a murine variant of *C. trachomatis*. The alignments were used to obtain phylogenetic trees with the program TreeView V.1.6.6.

**Statistical analyses**

Statistical analysis of the data was performed using the χ² or Fisher’s exact test. A p value of <0.05 was considered to be statistically significant. Absolute and relative frequencies and 95% accurate CIs were given.

**RESULTS**

A total of 40 (13.2%) rectal swabs were positive for *C. trachomatis*. To investigate strain variability, *ompA* PCR-positive products were purified and sequenced. The phylogenetic analysis of the *ompA* gene from those 40 *C. trachomatis*-positive specimens evidenced genotype E (n=15, 37.5%) as the most prevalent, followed by G (n=10, 25%), D (n=5, 12.5%), J (n=4, 10%) and L2b (n=2, 5%; figure 1). An illegible sequence was obtained in four cases (10%).

The association between genotype and clinical manifestations was analysed. While 25 (62.5%, 95% CI 46.2 to 78.7) patients of the 40 chlamydia-infected MSM showed any of the clinical symptoms described in table 1, no symptoms were present in 15 (37.5%, 95% CI 21.25 to 53.75) patients. The most frequent clinical symptom reported was anal ulcer (7 cases, 17.5%; 95% CI 4.47 to 30.52). It is important to emphasise that non-E genotypes were detected in 21 (84%, 95% CI 63.9 to 95.5) of the 25 patients with symptoms. On the other hand, the asymptomatic participants presented with an exclusively E genotype (p<0.001).

*C. trachomatis* occurred simultaneously to another STI in 27 patients (67.5%, 95% CI 51.7 to 83.2): syphilis (n=10, 25%), human papillomavirus (n=7, 17.5%) and HIV-1 (n=5, 12.5%), herpes simplex virus type 2 (HSV-2; n=3, 7.5%) and gonorrhoea (n=1, 2.5%; table 2).

With regard to the previous STI episodes, only two patients had prior syphilis and HSV-2 infections.

The two patients infected with the L2b strain were detected in 2011. They were Spaniards living in Spain, with no risk for acquisition abroad, and had negative...
HIV infection at the time of diagnosis. Both participated in high-risk sexual behaviour and reported multiple anonymous sexual contacts. While one of the patients evidenced no clear symptoms of LGV (only anal pruritus), the other sought medical attention for anorectal symptoms, presenting rectal pain, mucopurulent and bloody rectal discharge, consistent with a diagnosis of acute haemorrhagic proctitis. Furthermore, this last patient suffered from concurrent venereal warts. Swollen inguinal lymph nodes were not found in either patient.

Rectal and urethral samples were collected from 36 patients, where *C. trachomatis* was detected in both the samples of 2 (5.5%) patients, and in the rectal swab only in 13 (36.1%); no case of only urethral infection was detected.

**DISCUSSION**

Nowadays, there are different PCR-based test systems facilitating the identification of the *C. trachomatis* genotypes. A real-time multiplex PCR assay simultaneously

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**Figure 1** Phylogenetic analysis of OmpA gene sequences of 15 representative *Chlamydia trachomatis* isolates detected in the rectal samples collected from men who have sex with men (MSM) and of representative strains of *C. trachomatis* genotypes. *Chlamydia muridarum* (MoPnT) was used as an outgroup.
**Chlamydia trachomatis** strains among MSM

**Table 1** Clinical manifestations and genotypes

<table>
<thead>
<tr>
<th>MSM symptomatic</th>
<th>N</th>
<th>Genotype N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal fistula</td>
<td>1</td>
<td>D 5 (12.5)</td>
</tr>
<tr>
<td>Rectal blood loss</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Balanitis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Anal pain</td>
<td>2</td>
<td>E 4 (10)</td>
</tr>
<tr>
<td>Unspecific abdominal pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Perianal erythema</td>
<td>2</td>
<td>G 10 (25)</td>
</tr>
<tr>
<td>Anal ulcer</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Anal discharge and tenesmus</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Unspecific penile pain</td>
<td>1</td>
<td>J 4 (10)</td>
</tr>
<tr>
<td>Dysuria and pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Inguinal pain</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Anal pruritus</td>
<td>1</td>
<td>L2b 2 (5)</td>
</tr>
<tr>
<td>Proctitis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>MSM asymptomatic</td>
<td>15</td>
<td>E 11 (27.5)</td>
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<tr>
<td></td>
<td></td>
<td>Untyped 4 (10)</td>
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</tbody>
</table>

MSM, men who have sex with men.

**Table 2** Concurrent STIs in anorectal *Chlamydia trachomatis*-infected patients

<table>
<thead>
<tr>
<th>Genotypes</th>
<th>Syphilis (%)</th>
<th>HIV-1 (%)</th>
<th>Condylomas (%)</th>
<th>HSV-2 (%)</th>
<th>Gonorrhoea (%)</th>
<th>HBV (%)</th>
<th>Concomitant STIs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>6 (15.0)</td>
<td>3 (7.5)</td>
<td>2 (6.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>2 (5.0)</td>
<td>1 (2.5)</td>
<td>3 (7.5)</td>
<td>3 (7.5)</td>
<td>1 (2.5)</td>
<td></td>
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<tr>
<td>D</td>
<td>1 (2.5)</td>
<td>1 (2.5)</td>
<td>1 (2.5)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>J</td>
<td>1 (2.5)</td>
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<td></td>
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<tr>
<td>L2b</td>
<td></td>
<td></td>
<td></td>
<td>1 (2.5)</td>
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<td></td>
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<tr>
<td>Untyped</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10 (25.0)</td>
<td>5 (12.5)</td>
<td>7 (17.5)</td>
<td>3 (7.5)</td>
<td>1 (2.5)</td>
<td></td>
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</tr>
</tbody>
</table>

HBV, hepatitis B virus; HSV-2, herpes simplex virus type 2; STIs, sexually transmitted infections.
increase of this infection in our region, and evidence the existence of LGV reservoirs, suggesting the need for an attentive surveillance of LGV in Spain where the *C. trachomatis* surveillance scheme is conducted through a laboratory-based system (sentinel network composed by 18 laboratories located in 8 regions). Considering that this system does not require clinical reporting, LGV cases may remain undetected. In fact, the valuation of mild and atypical symptoms should imply quick laboratory confirmation that would allow the early implementation of appropriate therapy, contributing to the elimination of LGV reservoirs.

Surveillance programmes comprehending preventive strategies to control the onward transmission of *C. trachomatis* infection, namely by the screening of populations at risk such as MSM, are urgently needed and should include the early recognition (through highly sensitive and specific molecular techniques) and treatment of LGV cases.

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Contributors PM, PSL and JAB participated in the planning of the study, analysis and interpretation of the data, laboratory studies, and wrote the first draft of the manuscript, revised it critically and approved the final version. MJ and AT collected data and contributed to the acquisition of clinical information.

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REFERENCES


