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A Contagious Cause of Rectal Bleeding: Misleading Presentation of *Chlamydia trachomatis* Infection

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In February 2024, a 50-year-old man with no comorbidities was referred to the gastroenterology service for a 4-month history of rectal bleeding, abdominal pain, constipation, and weight loss (4 kg). Blood and stool tests showed mild anemia (Hb 11.9 gr/dL), elevated C-reactive protein (22 mg/L) and fecal calprotectin (270 mg/kg) levels. A colonoscopy performed at a first-level facility documented the presence of an ulcerated mass in the rectum. Histologic examination showed acute and chronic inflammation with plasma cells and eosinophils, with changes indefinite for dysplasia. A subsequent colonoscopy documented the presence in the rectum of a circumferential ulcerated area extending about 10 cm to the anal verge and narrowing of the rectal lumen and an additional ulcer of approximately 1 cm in the proximal part of the rectum (Figure 1a–c). The remaining colonic mucosa was normal. Histologic examination of biopsies taken on the ulcerated area confirmed the presence of acute and chronic inflammation with cryptic abscesses. Pelvic magnetic resonance imaging was negative for the presence of fistulas or abscesses and documented a thickening of the rectum walls. The patient's history was negative for recent travels or risky sexual behaviors. A possible diagnosis of Crohn's disease localized at the rectum was made and topical steroid therapy was initiated with partial improvement of constipation and a reduction in rectal bleeding. Meanwhile, rectal swabs were positive for *Chlamydia trachomatis*, while HIV and other sexually transmitted infections were excluded. In September 2024, a course of oral doxycycline antibiotic therapy was started, and one month later, an endoscopic examination documented marked improvement of the rectal ulcers (Figure 2). In May 2025, at the last follow-up visit, the patient was asymptomatic, and serological and fecal markers were negative.

Consent

Informed consent was signed by the patient.

Conflicts of Interest

Irene Marafini served as a consultant and speaker for AbbVie, Eli Lilly, and Galapagos. Joana Roseira received a speaking fee from AbbVie and Janssen. Giovanni Monteleone served as a consultant for First Wave BioPharma and Giuliani SpA, as a speaker for Takeda, Lilly, AbbVie, Galapagos, and Pfizer, and filed a patent related to the treatment of inflammatory bowel diseases with Smad7 antisense oligonucleotides.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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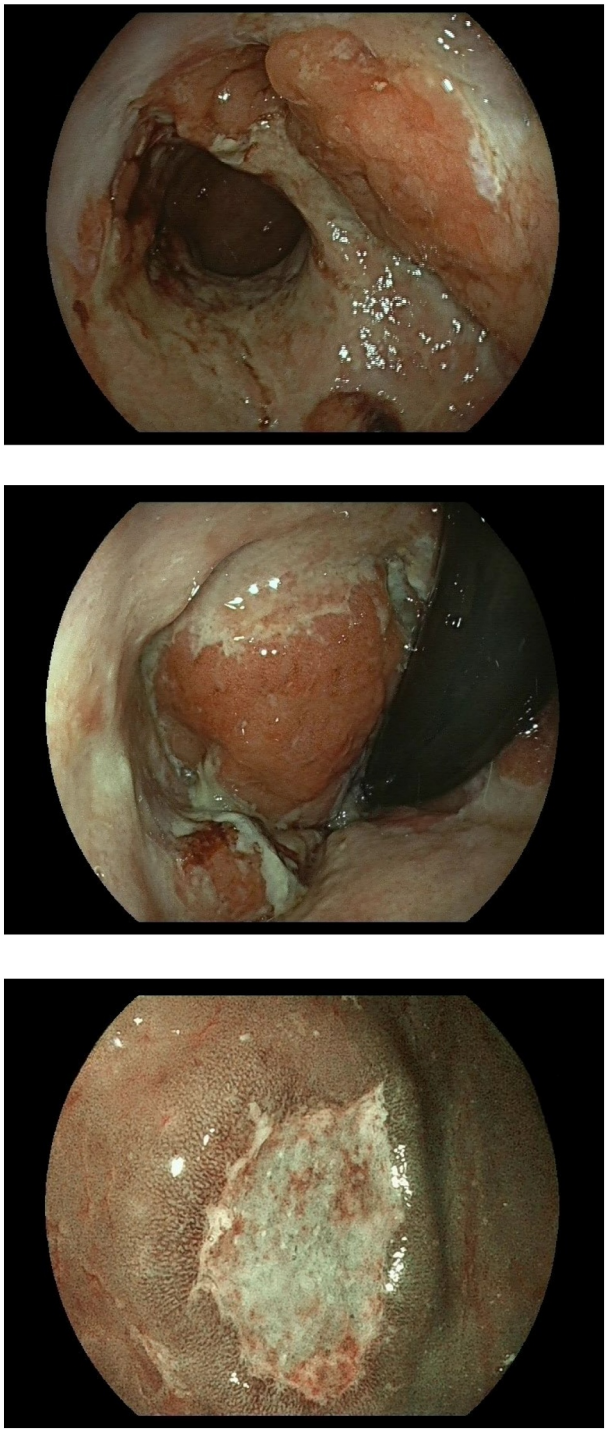

FIGURE 1 | Endoscopic images showing an ulcerated area in the rectum assessed both in forward view (a) and retroflexed view (b), along with an additional smaller proximal ulcer (c), at the time of diagnosis and before any treatment.

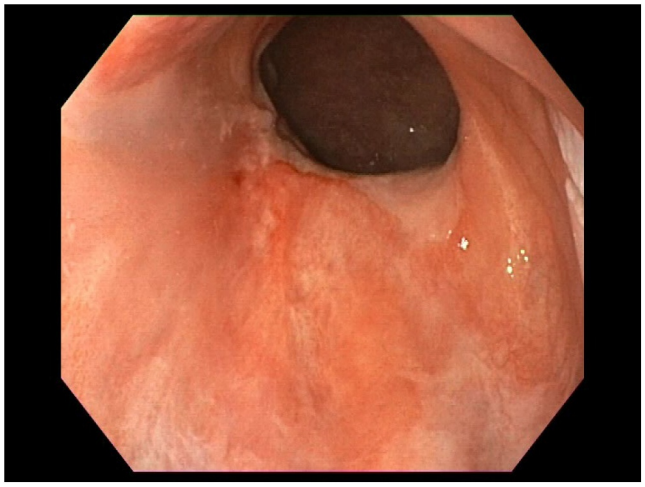

FIGURE 2 | Endoscopic image of the rectum at the site of the previous ulcer, taken after treatment, showing improvement of the lesion with a reduction in the ulcerated area.

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