Lymphoedema of the genitalia secondary to skin tuberculosis: report of three cases

Lymphoedema of the genitalia due to lymphatic obstruction is generally caused by filariasis, at times by neoplastic changes, and rarely, by lymphogranuloma venereum or donovanosis.1 We report its unusual occurrence in a patient with scrofuloderma and one with lupus vulgaris.

Case reports

CASE NO 1

A 25 year old woman with a 15 year history of recurrent swellings in the neck and groins had been treated with indinavir 800 mg relief. Later she had swelling of the vulva which brought her to the hospital. Examination revealed irregular scarring and few intermittently discharging sinuses over the submamillary and cervical areas. Multiple abscesses and sinuses were seen affecting the inguinal lymph nodes of both sides. The soft and swollen vulva showed vesicles, some of which had eroded. Systemic examination revealed no abnormality.

Investigations revealed a haemoglobin of 10 g/dl, white cell count 10·4 × 10⁹/L, differential—polymorphs 50, lymphocytes 34, eosinophils 26, erythrocyte sedimentation rate 44 mm/hr, and the first 24 hour urine protein was 1·8 g. Kulin 2 x 72 hours, 10 x Rays of the chest and pelvis disclosed no abnormality. Biopsy from an active lesion was sent for histopathology and culture in Lowenstein-Jensen medium. The former revealed a wrinkled and ulcerated epidermis. In the dermis an acute inflammatory infiltrate was seen around a necrotic area. The deeper dermis showed few tuberculoid structures with epitheloid and occasional Langherans giant cells surrounded by lymphocytes. No acid fast bacilli were seen on Ziehl-Neelsen stained sections. Mycobacterium tuberculosis was isolated on culture. Oral antitubercular treatment (ATT) comprising rifampicin 450 mg/day, 300 mg/day and pyrazinamide 750 mg twice daily was started. She was discharged after 2 months when that was seen after 2 months; pyrazinamide was stopped and the first two were continued. After 3 months the vulval swelling had decreased. She was advised to continue regular treatment but did not report to the hospital again.

CASE NO 2

A 30 year old beargar had occasionally discharging inguinal lesions of 10 years’ duration. They had started on the right side and spread over a period of time. There was no history of pulmonary tuberculosis. He had later noticed an increase in scrotal size. Examination revealed fluctuant areas and partially healed sinuses involving the inguinal lymph nodes of both sides. Healed areas were connected by thick scars extending into the suprapubic area. There was scanty to no discharge from the sinuses. The scrotum and penile skin were stretched but no oedematous (fig). The perianal region appeared normal.

Routine blood and urinalysis, and x rays of the chest and pelvic area were within normal

Defects associated with the use of high dose megestrol acetate

Thirty women with human immunodeficiency virus (HIV) weight loss more than 10% were enrolled in a study of weight gain using an oral suspension of megestrol acetate. Patients were randomised to receive either 400 mg or 800 mg of megestrol acetate per day for 24 weeks. A 28 year old HIV positive female participated in this study with the following chronology of events. At enrolment, she had had surgery 2 months earlier for an ectopic pregnancy with irregular menses, and her initial serum pregnancy test was positive. She was counsellled regarding the necessity of using barrier method contraception. She started taking megestrol acetate but failed to attend for follow-up clinic visits. Subsequently, pregnancy testing and ultrasonography demonstrated that she was 17 (SD 2) weeks pregnant. It was determined retrospectively that she had taken megestrol acetate, 400 mg per day, for 18 days from the 4th to the 7th week of pregnancy (by ultrasound dates). Her only other medication was 800 mg per day.

At 38 weeks gestation, she delivered by repeat caesarean section a live male infant, with normal Apgar scores, weighing 2633 g, with second degree hypospadias. The boy, now 7 months old and HIV negative, will require continuous medical management.

High doses of megestrol acetate in the first trimester of pregnancy may increase the risk of hypospadias. This warning appears in the drug manufacturer’s prescribing information.2 Caution needs to be exercised in prescribing megestrol acetate to HIV infected women with reproductive potential. Repeated counselling of patients on the use of adequate contraception and education of staff and patients regarding potential teratogenic effects of megestrol acetate should be stressed.

Correspondence


2 Accepted for publication 17 February 1997.

Hypospadias associated with the use of high dose megestrol acetate in an HIV infected woman

Megestrol acetate has been used to stimulate appetite and promote weight gain in patients with acquired immunodeficiency syndrome (AIDS) related cachexia and wasting.1 We report a case of hypospadias associated with the use of high dose megestrol acetate during the first trimester of pregnancy.

Hypospadias is a congenital malformation, in which the urethral meatus forms proximal to its normal position, resulting from incomplete fusion of the urethral groove during fetal development.1 (The normal process of fusion is brought about by androgens from the fetal testes during the first trimester of pregnancy.) Hypospadias is a relatively common abnormality, with a prevalence ranging from 1 in 300 to 1 in 1000 male births in the general population.1

Synthetic progestogens have been suggested as possible low risk teratogens for a range of congenital abnormalities.3 While the association of hypospadias with the use of standard doses of synthetic progestogens during pregnancy has been described,3 there have been no reports to date of birth.

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9 Megestrol acetate (Megace) product labelling and package insert.

10 Accepted for publication 3 March 1997.
Multiple abscesses, marked inguinal scarring, and genital lymphoedema.

We are grateful to Dr A D Bhattacharya, medical director, Hindustan Ciba-Geigy Ltd, for providing the antitubercular drug.

We audited the delivery of retested results to patients and how this was achieved (see table).

A total of 413 out of 701 patients (59%) received confirmed negative results as recommended. The department could have contacted 390 (56%) but a further 62 (9%), although requesting no contact, had provided an address and could possibly have been reached in exceptional circumstances.

Portsmouth has a high student population and the event occurred over a bank holiday weekend when it is possible some patients were away from their usual address. After 2 weeks local newspapers reported that all Portsmouth area retests had been negative so it is likely that some patients, knowing this, did not bother to return their forms as requested. The results for contactability are therefore almost certainly an underestimate.

Although not strictly comparable we contacted the Portsmouth cervical cytology screening unit and found that over a 5 year period 87% of 150,000 eligible women between 20 and 64 years of age responded to a written invitation for a first smear. Of those with an abnormal result <1% were unable to be contacted.

This was an unusual exercise requiring renewed contact with a large number of patients who had attended the GUM department over the previous 8 months. The results illustrate difficulties which could be encountered in any medium or long term follow up of this predominantly young, mobile population which often attends GUM clinics for a short term anxiety or medical episode.

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Delivering retested HIV results

In April 1996 the Department of Health arranged follow up of people who had been tested for HIV using the Abbott 1Mx HIV 1/2 third generation plus assay kit after four people with high levels of antibody were found to have been given false negative results. In the UK about 30,000 people had been tested using this kit between September 1995 and March 1996.

In Portsmouth 701 patients had been tested via the genitourinary medicine (GUM) department using the Abbott kit during this period and in accordance with the Department of Health directives we attempted to ensure that all received their results following retesting of stored serum—possible in all except one case where insufficient serum remained.

The news of the possible inaccuracy of HIV tests broke over the 1996 Easter weekend and a telephone line was provided to answer patient inquiries and explain arrangements for retesting and availability of results. The Portsmouth virology laboratory completed all results within 10 days. A letter confirming the negative result was sent whenever possible but inevitably some patients attended the department or phoned for results before they had received their letters. Patients were asked to confirm receipt of their result by signing and returning a form in an enclosed stamped addressed envelope. Any patient attending in person or requesting a result by phone was required to provide their date of birth, clinic card, clinic number, or other identification to confirm identity and maintain the usual confidentiality of GUM departments. All 701 patients had attended to receive their original results in person usually at same day testing clinics. We audited the delivery of retested results to patients and how this was achieved (see table).

We are grateful to Dr A D Bhattacharya, medical director, Hindustan Ciba-Geigy Ltd, for providing the antitubercular drug.

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Drug interactions of protease inhibitors

The interaction chart for protease inhibitors and lamivudine gives an impressive visual display of a very intricate subject. I would like to pass on a few comments with regard to ritonavir.

Comparing the interactions chart with the latest theoretical kinetic data on ritonavir:

(1) Alcohol is listed as a miscellaneous reaction of clinical significance. There are no data to suggest that alcohol is contraindicated.

(2) Current information predicted largely
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