confirmed the diagnosis of donovanosis. A 6 week course of doxycycline 100 mg twice daily was commenced, and the patient made a full recovery.

In view of the increased transmissibility of HIV in association with ulcerating genital infections, an effective and acceptable oral agent is required for the treatment of donovanosis. Few well designed controlled trials have addressed this problem. Effective treatment and prevention of ulcerating genital disease is important in the control of the spread of HIV. Clinicians investigating patients from tropical countries should be aware that trimethoprim and co-trimoxazole do not always eradicate donovanosis.


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Perforation of hard palate in lues maligna associated with HIV infection

Unusual oral and skin manifestations of infectious diseases may be observed in patients with HIV infection. These are quite different to the route to the clinician. Destructive bone disorders such as osteitis and osteomyelitis are well known complications of congenital and tertiary syphilis; they are rare complications of early acquired syphilis. We report a case of perforation of hard palate in lues maligna associated with HIV infection.

A 30 year old promiscuous male presented with a solitary genital ulcer and recurrent erythematous nodules and ulcers over the limbs (fig 1) and trunk for the past 5 months, associated with joint pains, swelling over the limbs, fever, headache, myalgia, and epistaxis. On further examination he had inguinal and epitrochlear lymphadenopathy. Oral examination revealed a mucosal patch and perforation over the hard palate (fig 2). Dark ground microscopy from the genital ulcer revealed several motile spirochaetes. VDRL was reactive in 1:128, TPPA and HIV (ELISA) were positive. Blood examination revealed normocytic normochromic anaemia with increased rouleaux formation, raised ESR (> 150 mm in the first hour). Liver function tests, antinuclear antibody (ANA), and double stranded DNA were within normal limits. The patient refused to undergo skin biopsy and lumbar puncture. In view of the clinical features, dark ground examination, and serological findings secondary syphilis (lues maligna) was considered. He was treated with procaine penicillin 24 units for 2 weeks. On follow up his skin lesions had healed.

The case is interesting because of early palatal perforation following lues maligna in this HIV patient. A review of the literature of the past 20 years revealed that of 1800 patients with early syphilis, less than 0.2% had evidence of periostitis, and there were no reports of destructive bone lesions. A recent review of bone and joint disease in association with HIV infection does not report syphilis related bone disease. Cases of HIV associated lues maligna with widespread, atypical ulcerations of the oral mucosa and skin have been reported.1 2 We postulate that destructive cell mediated immunity might have facilitated the rapid dissemination of spirochaetes invading bones and joints resulting in bone destruction. Numerous spirochaetes observed in bone biopsy specimens suggesting the aggressiveness of syphilis in a patient with concurrent HIV infection has been documented earlier.

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Sharing prescribing of continuous aciclovir treatment: effects of a new policy and general practitioner responses

Recent guidelines on the care of patients with genital herpes1 include reference to improved communication between local genitourinary medicine practitioners and general practitioners. This reinforces anecdotal reports that in some areas of the UK general practitioners and genitourinary medicine clinics were satisfactorily collaborating in the management of patients requesting continuous treatment with aciclovir.

In early 1996 the national reduction in HIV funding by 7-7% and the lack of designated additional funding for new antiretroviral drugs has resulted in extreme pressure on the drug budget within the directorate of HIV/GU medicine at the Chelsea and Westminster Hospital and prompted us to examine ways of extending collaboration with general practitioners with the secondary gain of achieving an overall reduction in our drugs budget. After discussion within the unit and with purchasers we attempted to reduce our prescribed deficit by restricting hospital prescribed therapies to treatments for HIV infection, and acute and new presentations of STDs. With the intention of preserving patient choice concerning confidentiality, however, we asked for our patients' specific consent to write to their general practitioners to request them to share responsibilities in the prescribing of continuous aciclovir for the prevention of recurrent genital herpes.

This policy took effect from April 1996, and during the following 5 months we approached 71 patients who were receiving regular prescriptions for continuous aciclovir to prevent recurrences of culture proved genital herpes from the genitourinary medicine clinic. Eight patients refused to have their herpes diagnosis and prescription needs disclosed to their general practitioners,
all as a result of concerns about confidentiality. All these patients have documented their decision in writing. The general practitioners offered to make a contribution to the costs if it was possible to continue on hospital prescriptions, but there is at present no logistical method for achieving this. Of the 63 general practitioners contacted, four refused to offer the recommended aciclovir treatment, predominantly citing the grounds of costs or not wishing to accept responsibility for the care. Overall, 59 patients were successfully referred to their general practitioners who continued to prescribe the recommended dosages of aciclovir. This did not reduce the frequency of visits to the gynaecological clinic as continued monitoring of the therapy, ongoing support, and counselling and discussion on when to cease therapy were carried out in the clinic according to our protocol.

Our experience suggests that the overwhelming majority of patients are prepared to give permission for the involvement of the general practitioner in the management of their genital herpes and that the majority of general practitioners are pleased to cooperate clinically in this management. All newly diagnosed patients with genital herpes are now being directly asked for their permission to involve their general practitioner in their care and we will continue to audit our experience of the uptake of this. A small proportion of patients continue on hospital prescriptions because of their concern about confidentiality.

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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 fifth and sixth gestation.) Hypospadias is a relatively common abnormality, with a prevalence ranging from 1 in 300 to 1 in 1000 male births in the general population.1-4

Synthetic progestogens have been suggested as possible low risk teratogens for a range of congenital abnormalities.1,5 While the association of hypospadias with the use of standard doses of synthetic progestogens during pregnancy has been described,1 there have been no reports to date of birth defects associated with the use of high dose megestrol acetate. Thirty women with immunodeficiency virus (HIV) infection had lost more than 10% weight loss, 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 the 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 negative. She was counselled 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 vitamin supplements per day.

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

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.1 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.

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9 Megestrol acetate (Megace) product labelling and package insert. Accepted for publication 3 March 1997

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 venerum or Donovanosis.1 We report its unusual occurrence in a young woman 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 groin daily was started on indinavir as treatment for HIV. Later she had swelling of the vulva which brought her to the hospital. Examination revealed irregular scarring and few intermittently discharging sinuses over the submandibular and cervical areas. Multiple abscesses and sinuses were seen affecting the inguinal lymph nodes of both sides. The soft and swollen vulva showed two vesicles, some of which had eroded. Systemic examination revealed no abnormalities.

Investigations revealed a haemoglobin of 10 g/dl, white cell count 10.4 x 10^9/l, differential—polymorphs 50, lymphocytes 34, eosinophils 26, erythrocyte sedimentation rate 40 mm in the first hour. X rays of the chest and pelvis showed no abnormality. Biopsy from an active lesion was sent for histopathology and culture in lowenstein-jensen medium. The former revealed a thinned and ulcerated epidermis. In the dermis an acute inflammatory infiltrate was seen around a necrotic area. The deeper dermis showed few tuberculoid structures with epithelioid and occasional Langhans giant cells surrounded by lymphocytes. No acid fast bacilli were demonstrated in 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. Swelling at vulva 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 beaggard had occasionally discharged 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 scrotal displacement due to discharge from the sinuses. The scrotum and penis skin were stretched and oedematous (fig). The perinael region appeared normal.

Routine blood and urinalysis, and X rays of the chest and pelvic area were within normal limits.