all as a result of concerns about confidentiality. All these patients have documented their decision in writing. One patient 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 prescribe 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 genitourinary medicine 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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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.^{1,2} 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.³ (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.^{4,5}

Synthetic progestogens have been suggested as possible low risk teratogens for a range of congenital abnormalities.^{6,7} While the association of hypospadias with the use of standard doses of synthetic progestogens during pregnancy has been described,⁸ there have been no reports to date of birth

defects associated with the use of high dose megestrol acetate.

Thirty women with human immunodeficiency virus (HIV) infection, and 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 zidovudine, 600 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 corrective surgery.

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.⁹ 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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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 venereum or donovanosis.¹ We report its unusual occurrence in two patients 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 taken indigenous treatment with no 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 submandibular 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 $10.4 \times 10^9/l$, differential—polymorphs 50, lymphocytes 34, eosinophils 26, erythrocyte sedimentation rate 40 mm in the first hour. The enzyme linked immunosorbent assay to detect HIV was negative. Mantoux test to 0.1 ml of purified tuberculin (Span Diagnostics, Surat, India) injected on the volar surface of forearm read 40 mm $\times$ 40 mm after 72 hours. $\times$ 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 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 Langerhans giant cells surrounded by lymphocytes. No acid fast bacilli were demonstrable 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. Significant improvement 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 beggar 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 moderate discharge from the sinuses. The scrotum and penile skin were stretched and oedematous (fig). The perianal region appeared normal.

Routine blood and urinalysis, and $\times$ rays of the chest and pelvic area were within nor-

Multiple abscesses, marked inguinal scarring, and genital lymphoedema.

mal limits. The intraderman tuberculin test read 26 mm × 26 mm. Smears stained with Gram's and Ziehl-Neelsen's revealed no organisms. Culture was negative for *M tuberculosis* and *Actinomyces*. Histopathology from the inguinal area was similar to case no 1. The second biopsy from a penile site showed normal epidermis and evidence of dermal fibrosis indicating late lymphoedmatous changes. After 9 months of ATT all signs of active disease had subsided with no significant decline in the genital oedema on follow up.

CASE NO 3

A 28 year old man presented with a lesion on the buttocks for 4 years, diagnosed elsewhere on histopathology as LV. Mantoux test had read 20 mm × 20 mm and chest x ray was reported normal. He had been taking ATT for 3 months. Skin lesions had responded but the scrotal swelling persisted. A large atrophic area over both buttocks extending into the medial aspects of the upper thighs was seen. At places erythematous keratotic plaques were present. The inguinal lymph nodes were bilaterally enlarged, discrete, and non-tender. After 6 months of ATT the skin lesions had completely subsided with some reduction in the swelling of scrotum and penis. ATT was stopped and a year later the genitalia resumed the normal appearance.

Discussion

Approximately one sixth of patients with secondary skin tuberculosis present with anogenital lesions without lympho-occlusive complications.^{2,3} Occasionally, gigantic overgrowth of the soft tissue of the lower limb following lymphatic obstruction has been seen after repeated attacks of tuberculous lymphangitis.⁴ All our patients had lymphoedema of the genitalia because the superficial horizontal group of inguinal nodes which drain lymph from the prepuce, penile skin, scrotum, vulva, and gluteal region were severely affected. In two the inguinal areas were riddled with scrofuloderma and in the third lupus vulgaris had affected the buttocks. The Mantoux test was strongly positive and *M tuberculosis* was recovered in one with scrofuloderma. Demonstration or recovery of acid fast bacilli is often unsuccessful in lupus vulgaris and scrofuloderma because the organisms are scarce⁵; hence the diagnosis rests on a strong tuberculin reaction, histopathology, and response to ATT. Lymphoedema in the patient with lupus vulgaris regressed well because the impaired lymphatic circulation was restored following ATT, but in scrofuloderma there was more destruction resulting in fibrosis and scars.

Method of delivery of retest results

Attended GUM department	48	42 contactable from recorded details
Phoned GUM department	74	59 contactable from recorded details
False details given	2	needed repeat blood sample and retesting
Letters sent	438	298 replies: 279 signed by patient
		5 unsigned
No contact requested	62	14 not known at address
No address recorded	61	address recorded in notes
Phone contact	16	10 results given
		1 gone abroad
		3 not known at number
		2 disconnected
Total	701	

We are grateful to Dr A D Bhatt, medical director, Hindustan Ciba-Geigy Ltd, for providing the anti-tubercular drugs.

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Accepted for publication 8 April 1997

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 retesting 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).

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 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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Accepted for publication 8 April 1997

Drug interactions of protease inhibitors

The interaction chart for protease inhibitors and lamivudine¹ 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