defects associated with the use of high dose megestrol acetate.

Thirty women with human immunodeficiency virus (HIV) who had 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 participant failed 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 positive. 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 ultrasoundography 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 medication was zidovudine 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 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. 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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Lymphoedema of the genitalia second 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 girl with scrofuloderma and one with lupus vulgaris.

Case reports

Case report 1
A 25 year old woman with a 15 year history of recurrent swellings in the neck and groin 2 days was initiated on indinavir and ritonavir 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 abnormalities.

Investigations revealed a haemoglobin of 8.10 g/dl, white cell count 10.4 x 10^9/l, differential—polymorphs 50, lymphocytes 43, eosinophils 26, erythrocyte sedimentation rate 40 mm in the first hour. She still had 28 x Rats of the chest and pelvis disclosed no abnormality. Biopsy from an active lesion was sent for histopathology and culture with Lowenstein-Jensen medium. The former revealed a thrinned 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 demonstrable in Ziehl-Neelsen stained sections. Mycobacterium tuberculosis was isolated on culture. Oral antitubercular treatment (ATT) comprising rifampicin 450 mg/day, isoniazid 300 mg/day and pyrazinamide 750 mg twice daily was started. Skin treatment was with indinavir for 2 months 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 ATT but did not report to the hospital again.

Case report 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 heated sinus located on the inguinal lymph nodes of both sides. Healed areas were connected by thick scars extending into the suprapubic area. There was scanty scrotal discharge from the sinuses. The scrotum and penile skin were stretched and oedematous (fig). The perianal region appeared normal.

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

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. (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.2

Surgical inguinoscrotal hyperplasia is a possible low risk teratogen 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,4 there have been no reports to date of birth
Multiple abscesses, marked inguinal scarring, and genital lymphoedema.

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

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Method of delivery of retes results

<table>
<thead>
<tr>
<th>Attended GUM department</th>
<th>Phoned GUM department</th>
<th>False details given</th>
<th>Letters sent</th>
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<tbody>
<tr>
<td>48</td>
<td>74</td>
<td>2</td>
<td>438</td>
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<tr>
<td>42 contactable from recorded details</td>
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<tr>
<td>59 contactable from recorded details</td>
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</tbody>
</table>
needed repeat blood sample and retesting
296 replies: 279 signed by patient
5 unsigned
14 not known at address

Address recorded in notes
10 results given
1 gone abroad
3 not known at number
2 disconnected

Total 701

We attended all patients who had been tested for HIV using the Abbott 1Mx HIV 1/2 third generation plus assay kit after four years with high levels of antibody were found to have 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 retes 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 who had attended to receive their original results in person usually at same day testing clinics. We audited the delivery of retes 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 retes 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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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