to all as a result of concerns about confidentiality. All these patients have documented their decision in writing. The 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 after 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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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 venerenum or Donovanosis. We report its unusual occurrence in a 50 year old female 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 daily was started on indinavir and stavudine. She had swelling of the vulva which brought her to the hospital. Examination revealed irregular scarring and fibrosis of the vulva. She had no previous history of genital lesions and the vulval lesions were seen by her general practitioner on two occasions without any treatment. She was referred to our clinic and examined.

The vulva was noted to be diffusely thickened and indurated. There was no evidence of venereal disease. She had not been pregnant or had a history of miscarriages. She was born in Nepal and had been living in the UK for the past 13 years. She had no history of tuberculosis. She did not have any history of skin disease or scrofuloderma. She had no history of lymphaticovenous malformation.

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

Meglstrol 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.1 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) positive females with 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 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 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 at this time was 600 mg per day. At 38 weeks gestation, she delivered by repeat caesarean section a live male infant, with normal Appar scores, weighing 2633 g, with second degree hypospadias. The boy, now 7 months old and HIV negative, will require circumcision.

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.

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

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Multiple abscesses, marked inguinal scarring, and genital lymphoedema.

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

Method of delivery of retest results

<table>
<thead>
<tr>
<th>Attended GUM department</th>
<th>Phoned GUM department</th>
<th>False details given</th>
<th>Letters sent</th>
<th>No contact requested</th>
<th>No address recorded</th>
<th>Phone contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>74</td>
<td>2</td>
<td>438</td>
<td>62</td>
<td>61</td>
<td>16</td>
</tr>
</tbody>
</table>

42 contactable from recorded details
59 contactable from recorded details
need repeat blood sample and retesting
298 replies: 270 signed by patient
5 unsigned
14 not known at address
10 results given
1 gone abroad
3 not known at number
2 disconnected
Total 701

Discussion

Approximately one sixth of patients with secondary skin tuberculosis present with anogenital lesions without lympho-occlusive complications. Occasionally, gigantic overgrowth of the soft tissue of the lower limb following lymphatic obstruction has been seen after repeated attacks of tuberculous lymphangitis.

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 ridged 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 scarce; 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.

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