all as a result of concerns about confidentiality. All these patients have documented their decision in writing. Having offered 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 and the remainder offered 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.

Barbara Vonau
Department of HIV/Genitourinary Medicine
St Stephen's Centre
Chelsea and Westminster Hospital
369 Fulham Road, London SW10 NH

Correspondence to: Dr Barbara Vonau.

Accepted for publication 17 February 1997

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

Mestegestrol 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 mestegestrol 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.2 Hypospadias is a relatively common abnormality, with a prevalence ranging from 1 in 300 to 1 in 1000 male births in the general population.3 Synthetic progestogens have been suggested as a possible low risk teratogen for a wide range of congenital abnormalities.4 While the association of hypospadias with the use of standard doses of synthetic progestogens during pregnancy has been described,5 there have been no reports to date of birth defects associated with the use of high dose mestegestrol acetate.

Thirteen women with immunodeficiency virus (HIV) infection and mean weight 60% more than 10% weight loss, were enrolled in a study of weight gain using an oral suspension of mestegestrol acetate. Patients were randomised to receive either 400 mg or 800 mg of mestegestrol 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 surgery 3 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 mestegestrol 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 mestegestrol 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 conjugated estrogens 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 counselling.

High doses of mestegestrol 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 mestegestrol 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 mestegestrol acetate should be stressed.

David J Farrar
Venee Aromin
Susan C Uvin
Timothy P Flanagan
Maria D Mileno
Department of Medicine
The Miriam Hospital
Brown University School of Medicine
Providence, Rhode Island, USA

Correspondence to: Dr M D Mileno, Immunology Center, The Miriam Hospital, 164 Summit Avenue, Providence, RI 02906, USA.

9 Mestegestrol 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 venereum or donovanosis. We report its unusual occurrence 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 groins had been indigent and relief. Later she had swelling of the vulva which brought her to the hospital. Examination revealed irregular scarring and a few intermittently discharging sinuses over the subumbilical 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 10×10⁶, differentials—polymorphs 50, lymphocytes 34, eosinophils 26, erythrocyte sedimentation rate 40 mm in the first hour. HIV and Hepatitis B were negative. Tests for syphilis were negative. Histological examination revealed a chronic inflammatory infiltrate. The former had a history of tuberculosis and a lesion of scrofuloderma on the neck and shoulders. She was treated with isoniazid, rifampicin and pyrazinamide. She attended the clinic monthly and a follow up examination was done at 3 months. She attended twice a year after that and was last seen 2 years after her hospital admission. She had no complications and was doing well.

Case report 2

A 30 year old bearded 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 noticed an increase in scrotal size. Examination revealed fluctuant areas in the inguinal lymph nodes of both sides. They were not tender and no history of lymph node infection. They were connected by thick scars extending into the suprascrotal area. There was scrotal edema and 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 values.
Multiple abscesses, marked inguinal scarring, and genital lymphoedema.

Method of delivery of test results

<table>
<thead>
<tr>
<th>Method of delivery of test results</th>
<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>Total</td>
<td>701</td>
<td>48</td>
<td>74</td>
<td>2</td>
<td>438</td>
<td>62</td>
<td>61</td>
</tr>
</tbody>
</table>

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

V RAMESH

VASANThI RAMESH

Departments of Dermatology and Surgery, Sajdarjung and Dr Ram Manohar Lohia Hospitals, New Delhi, India

Correspondence to: Dr V Ramesh, Sector 12, 1082, RK Puram, New Delhi-110 022, India


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 had been found to have obtained 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 over 300 tests in 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 the 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 weekend. 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.

M TOBIN

MIDDLETON

Department of Genitourinary Medicine, St Mary’s Hospital, Milton Road, Portsmouth, Hants PO3 6AD

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