general population in this high risk area, HIV test requests in the general practice sentinel network in Amsterdam have been recorded from 1989 to 1992, and from September 1994 to September 1996. The coverage of the network was reduced from 10% (1989–92) to 7% (1994–5) and 2% (1995–6) of the Amsterdam population, but it remained representative in terms of distribution of practices over the city and sex-age distribution. Through the years, homosexual men accounted for 15–20% of the HIV test requests and drug users for 3–6%.

The average yearly incidence of test requests between 1989 and 1992 was 5·3 (4·7–5·5) per 1000 patients, after which it decreased to 3·9 (1994–5) and 2·6 (1995–6). The average percentage of positive test results between 1989 and 1996 was 7·0 (5·9–9·0), with peaks in 1991 (8·6%) and 1994–5 (9·0%).

In the nationwide general practice sentinel network, which covers about 1% of the Dutch population, the yearly incidence of HIV test requests per 1000 patients rose steadily from 0·8 (1988) to 1·8 (1993). Of the tests performed, an average of 1% were positive.[2]

The higher incidence of test requests and positive test results in general practices in Amsterdam confirm the status of Amsterdam as a high risk area for HIV. The marked decline since 1992, in the incidence of test requests in general practices in Amsterdam is interesting, as it contradicts the trend seen elsewhere in the Netherlands. This may well reflect a certain saturation towards HIV testing among the general population in a high risk area.

Towards the end of 1996, the new effective combination treatment for HIV became available.[3] This is expected to stimulate HIV test requests from individuals who have been at risk for HIV but have not tested before. Given the trend described here, it remains to be seen if a rise in HIV test requests will occur in Amsterdam.

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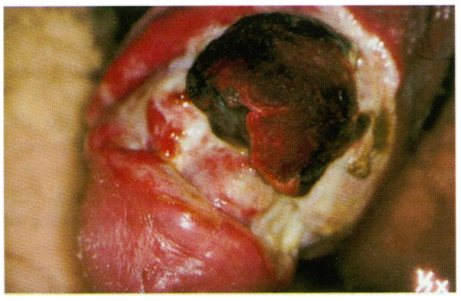
Genital ulceration revealing a primary cutaneous anaplastic lymphoma

A 35 year old man first noticed an indurated plaque of the glans penis in 1990. In March 1991, the plaque extended and became painful. Although various antiseptics and antibiotics were applied, he developed an ulceration on the same area in January 1992, which progressively extended to the prepuce. A posthectomy was carried out in March 1992. In June 1992, he had an ulceration of 4 cm diameter, covered by a plaque of gangrene (fig). He was then admitted in the department of dermatology in Strasbourg. During this 2 year period, TPHA and VDRL were negative four times, as well as ELISA for HIV antibodies. Cultures from the



Large ulceration of the penis centred by a plaque of gangrene.

ulceration showed only the presence of *Staphylococcus epidermidis*. A first biopsy showed in January 1992 a dense granulomatous infiltrate containing numerous plasma cells but no atypical lymphocytes. The prepuce was also examined and did not show malignant changes. In June 1992, the patient suddenly developed an inguinal adenopathy and his general condition worsened, with fever (39°C) and intense local pain. The histopathological examination of the fat tissue around the enlarged but cytologically normal lymph node showed areas of necrosis, containing a dense infiltrate of malignant cells with highly atypical nuclei and numerous mitoses. The muscular wall of a large vein was infiltrated by neoplastic cells. In the very depth of the genital ulceration, the same malignant cells were also present, which expressed T lymphocyte markers (common leucocyte antigen and CD3) but no B lymphocyte markers (CD20) and CD30 antigen in less than 10% of cells. The final diagnosis was a primary cutaneous anaplastic large cell lymphoma, which was CD30 negative and showed a marked angiotropism. Total body computed tomography scan and bone marrow biopsy excluded visceral localisation.

The patient was first treated by VP16, cyclophosphamide, vincristine, prednisone, bleomycin, and adriamycin. Nevertheless, there was no regression of the penile ulceration. He was then treated by surgical excision of the persisting lymph nodes and genital necrotic tissue and by a second chemotherapy regimen (dexamethasone, cytarabine, and cisplatin) that allowed a regression of the penile ulceration and a softening of the surgical scar of the groin. Four months later, a local progression of the disease in the inguinal area was noted and he developed a strong increase in ALT and AST levels, circulating blasts and disseminated intravascular coagulation. The patient died in March 1993 because of haemorrhagic complications.

To our knowledge, the occurrence of a primary lymphoma of the penis was never described among malignant tumours causing genital ulcerations.[1] The diagnosis of lymphoma was extremely difficult in this case because the clinical presentation was unusual and the two first histological examinations failed to show malignant changes. The diagnosis of neoplasia was possible only after locoregional spreading has occurred. This lymphoma probably induced a persistent ulceration because of its angiotropism, as it is described in the "lethal midline granuloma" which is considered to be a T cell lymphoma.[2] Cutaneous lymphomas other than mycosis fungoides are rare and constitute a heterogeneous group of neoplasms.[3] Such lymphomas have not yet been described in the male genitalia, but primary lymphomas of the vulva have been recorded.[4–6] The classification of this disease is difficult. It could be included in spectrum of the anaplastic large cell lymphoma (CD30 negative). The involvement of large vessels by atypical lymphocytes could be consistent with an angiotrophic lymphoma.

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High level ciprofloxacin resistant gonorrhoea imported from Russia

Sherrard and colleagues recently expressed concern regarding importation of syphilis and other sexually transmitted diseases among British travellers to Russia and Poland.[1] We report a case of multiply resistant gonococcal infection imported into the United Kingdom from Russia which failed single dose ciprofloxacin therapy.

A 35 year old British truck driver returned from Russia with a 3 week history of urethral discharge and dysuria following unprotected vaginal intercourse with a casual female partner in Russia. He had not had intercourse with any other partner for 5 months. He received six tablets of unknown content for the discharge in Russia but these had had no effect on his symptoms. His mucopurulent discharge was confirmed on examination and microscopy demonstrated intracellular Gram negative diplococci. He was treated with single dose ciprofloxacin 500 mg and a week's course of doxycycline. He returned after 4 days with no improvement in his symptoms and a repeat Gram stain was still positive for presumptive gonococcal infection. To cover the possibility of ciprofloxacin resistant gonorrhoea, he was given spectinomycin 2 g intramuscularly. He was microbiologically and clinically cured of gonorrhoea 1 month later following return from a further episode of travelling.

Neisseria gonorrhoeae was cultured from urethral specimens taken before and after ciprofloxacin therapy. Susceptibility testing with a 30 µg nalidixic acid disc predicted ciprofloxacin resistance which was confirmed by the PHLS Gonococcal Reference Laboratory in Bristol where the isolate's ciprofloxacin minimum inhibitory concentration (MIC) was shown to be 16 mg/l con-