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.

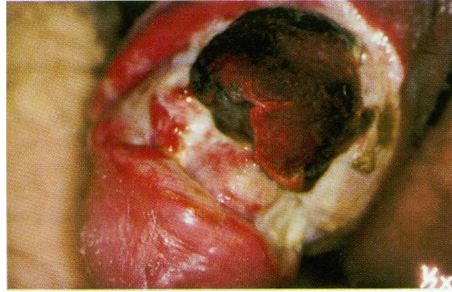
L WIGERSMA
Department of General Practice, Academic Medical Centre, Meibergdreef 15, 1105 AZ Amsterdam, Netherlands

1 Bindels PJE. Surveillance and survival studies on HIV/AIDS in Amsterdam. PhD thesis. Amsterdam: University of Amsterdam, 1996.
2 Moons MAW, Peters L, Bartelds AIM, Kerssens JJ. Concern about AIDS in general practice. *BMJ* 1996;**312**:285–6.
3 Hammer SM. Advances in antiretroviral therapy and viral load monitoring. *AIDS* 1996;**10** (suppl 3):S1-S11.

Accepted for publication 20 May 1997

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 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.



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

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.

B CRIBIER
D LIPSKER
E GROSSHANS
Clinique Dermatologique, Hôpitaux Universitaires, Strasbourg, France
C DUHEM
C CAPESIUS
M DICATO
Département d'Hémato-Cancérologie, Centre Hospitalier de Luxembourg

Correspondence to: B Cribier, MD, PhD, Clinique Dermatologique des Hôpitaux Universitaires, 1 place de l'Hôpital 67091 Strasbourg Cedex, France.

1 Mroczkowski TF, Martin DH. Genital ulcer disease. *Dermatol Clin* 1994;**12**:753–64.
2 Ishii Y, Yamanaka N, Ogawa K, Yoshida Y, Takami T, Matsuura A. Nasal T cell lymphoma as a type of so-called "lethal midline granuloma". *Cancer* 1982;**50**:2336–54.
3 Joly P, Thomine E, Lauret P. Cutaneous lymphomas other than mycosis fungoides. *Sem Dermatol* 1994;**13**:172–9.
4 Ferrando-Marco J, Martorell MA, Carrato A, Navarro JT. Primary vulvar lymphoma presenting as a clitoridal tumor. *Acta Obstet Gynecol Scand* 1992;**71**:543–6.
5 Tuder RM. Vulvar destruction by malignant lymphoma. *Gynecol Oncol* 1992;**45**:52–7.
6 Höffkes HG, Schumann A, Uppenkamp M, Teschendorf C, Schindler AE, Parwaresch R, *et al.* Primary non-Hodgkin's lymphoma of the vagina. *Ann Hematol* 1995;**70**:273–6.

Accepted for publication 29 May 1997

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-

Genitourin Med: first published as 10.1136/sti.73.4.325-a on 1 August 1997. Downloaded from http://sti.bmj.com/ on October 1, 2023 by guest. Protected by copyright.

sistent with high level ciprofloxacin resistance. MICs were also performed for benzylpenicillin (> 10 mg/l), ceftriaxone (0·004 mg/l), spectinomycin (16 mg/l), and tetracycline (4 mg/l). The isolate was β lactamase positive and contained the 4·4 MDa Asian β lactamase plasmid as well as 2·6 MDa cryptic and 24·5 MDa conjugative plasmids. Phenotyping demonstrated a non-requiring auxotype and a WII/WIII serotype.

This patient returned from Russia infected with a gonococcus that exhibited both high level ciprofloxacin and penicillin resistance and low level tetracycline resistance. Dissemination of such strains within the United Kingdom has implications for current therapeutic first line therapies which consist predominantly of single dose ciprofloxacin or penicillin regimens.[2] High level ciprofloxacin resistance is rare in the United Kingdom and published cases suggest Spain[3] and South East Asia[4] may be foci for importation of such strains into the United Kingdom. It is recommended that clinical staff seeing patients with potential gonorrhoea obtain adequate travel histories in order to decide upon an appropriate first line antibiotic therapy. Spectinomycin resistance still remains a minor problem worldwide and single dose intramuscular spectinomycin is thus likely to be effective in treating the majority of imported combined ciprofloxacin and penicillin resistant gonococcal infections seen in the United Kingdom. Single dose intramuscular ceftriaxone or cefuroxime are possible therapeutic alternatives in this situation.

We are grateful for the typing and MIC data provided by the PHLS Gonococcal Reference Laboratory, Bristol.

DA LEWIS
MG BROOK
Patrick Clements Clinic
MS SHAFI
PHL Microbiology Department, Central Middlesex Hospital, Park Royal, London NW10 7NS

1 Sherrard J, Luzzi G, Edwards A. Imported syphilis and other sexually transmitted infections among UK travellers to Russia and Poland. *Genitourin Med* 1997;73:75.
2 Fitzgerald M. Antibiotic treatment for gonorrhoea in the UK. *Genitourin Med* 1997;73: 149.
3 Birley H, McDonald P, Carey P, Fletcher J. High level ciprofloxacin resistance in *Neisseria gonorrhoeae*. *Genitourin Med* 1994; **70**:292–3.
4 Kam KM, Wong PW, Cheung MM, Yee NKY, Lo KK. Quinolone-resistant *Neisseria gonorrhoeae* in Hong Kong. *Sex Transm Dis* 1996; **23**:103–8.

Accepted for publication 12 June 1997

MATTERS ARISING

Genital *Chlamydia trachomatis* infection in women in a Nigerian hospital

I read the report of Amin and colleagues[1] on the outcome of opportunistic screening for *Chlamydia trachomatis* in women seen in the antenatal and gynaecology clinics in north east Nigeria with interest. The prevalence of 9% was comparable with our study population[2] reported from the north east of England. However, the authors, in screening only the cervical site, would have failed to pick up those women in whom urethral sites are the only site of infectivity.[2,3]

Of concern is the dearth of data on the analogous male partner(s)[4] and their consort(s): 18% of the study sample were in a polygamous marriage, untested and untreated individuals will remain a reservoir of infections.

The findings of the authors in this supposedly low risk population, in tandem with the reported increase in HIV infection from seroepidemiological studies in antenatal clinics in Maiduguri, north east Nigeria[5] should serve as a catalyst in the development of effective sexual health services, led by obstetricians and gynaecologists[6] offering women routine opportunistic screening for sexually transmitted infections, encouraging attendance and treatment of their male partner(s), and offering family planning and contraception. These measures will ultimately enhance the sexual health of the catchment population with a concomitant reduction in the sequel of sexually transmitted infections including HIV/AIDS.

TUBONYE C HARRY
Bure Clinic, Department of GU Medicine, James Paget Hospital NHS Trust, Lowestoft Road, Great Yarmouth NR31 6LA

1 Amin JD, Zaria LT, El-Nafaty AU, Mai AM. Genital *Chlamydia trachomatis* infection in women in a Nigerian hospital. *Genitourin Med* 1997;**73**:146–7.
2 Harry TC, Rashid S, Saravanamuttu KM. Multiple testing of multiple sites in the diagnosis of chlamydial infection in women. *Int J STD AIDS* 1997;**8**:139.
3 Opaneye AA, Muttu KM, Rashid S. Screening for genital *Chlamydia trachomatis* infection in female patients. *Genitourin Med* 1994;**70**:71.
4 Harry TC. Reproductive tract infections and abortion among adolescent girls in rural Nigeria. *Lancet* 1995;**345**:869.
5 Harry TO, Bukbuk DN, Idrisa A, Akoma MB. HIV infection among pregnant women: a worsening situation in Maiduguri, Nigeria. *Trop Geographical Med* 1994;**46**:46–7.
6 Harry TC. The case against new reproductive technologies in developing countries. *Br J Obstet Gynaecol* 1997;**104**:385.

BOOK REVIEWS

The Guide to Living with HIV Infection. By J G BARTLETT & A K FINKBEINER. Baltimore: The Johns Hopkins University Press, 1996. (Pp 440; £11.00.) ISBN 0 8018 5359 1.

To echo the sentiments of Joseph Maier, the author of the prologue to this guide, I am living with HIV, not an HIV sufferer or an HIV victim. It is clear that the authors appreciated the importance of these feelings and this is the main reason why I found what could have been just another dry reference book, such a good read.

Clear, concise explanations and guidance encouraged me to read the more technical sections on infections and treatments, subjects which many of us with HIV find difficult to absorb because of offputting medical jargon and our emotional responses to information about what could happen to us.

As the guide was written from a US perspective, many of the legal and practical aspects of HIV it discussed are not strictly applicable to the UK, although there are similarities in themes and frameworks between the two countries. The information on transmission and prevention covered already fairly well rehearsed material, although it would be useful for the newcomer to HIV.

The use of "the voices" of people with HIV to introduce subjects and to illustrate alternative attitudes and approaches to various issues helped to sustain my interest and gave credence to the guidance which was offered. I felt the authors had actually listened to the thoughts and feelings of those who are experiencing the devastating effects of HIV, and that they had given serious consideration to practical and emotional strategies for dealing with these effects, rather than merely trotting out platitudes. They also highlighted that living with HIV is not only possible, but that life can continue to have meaning and be fulfilling for those infected and for their friends and families.

The sections which dealt with emotions, relationships, and dying were the most interesting, relevant, and moving for me. The guide covered the most typical range of emotional reactions experienced by those of us dealing with HIV, including anger, fear, depression, hope, and guilt but did so in a way which was accepting, not dismissive or patronising. It also highlighted that as many people react to HIV in different ways, so they cope in different ways and there is no right approach. The powerful and moving chapter on interpersonal relationships included ideas on how to deal with some of the common problems experienced by people with HIV and by carers.

Living with HIV means being "faced with that ultimate fear [death] all the time" (p98) and the authors tackled this most difficult subject in a calm, gentle and encouraging way. The chapter on dying helped me to think about my own death and how I will face it. The most powerful message for me in the guide is that I can face death because "The person who has lived is the same as the person who will die. If you know yourself at all, you know how you will die" (p292). The question is, will I have time to know myself?

JANE JUMA

Women and their Health. By SATISH MITTAL. London: Clarewood Publishers, 1997. (Pp 284; £9.95.) ISBN 0 9529481 09

In the preface of this book, the author states his intention to provide up to date medical information on topics of everyday concern for women and a companion book for practice nurses. The book covers an enormous variety of subjects from eating disorders to breast cancer and the detail included in some sections is remarkable. However, the relevance of including the eight anatomical variations of the hymen is questionable, as are the instructions on how a woman may examine her own cervix with the aid of a mirror, torch, KY jelly, and speculum bought from a medical shop!

Unfortunately, this publication is plagued by typographical, grammatical, and factual errors. Sections which include "cullingus", the retractile clitoris, and the statement that "genital herpes can be caught from toilet seats", result in the book losing some credibility. In addition, some of the information is

Genitourin Med: first published as 10.1136/sti.73.4.325-a on 1 August 1997. Downloaded from http://sti.bmj.com/ on October 1, 2023 by guest. Protected by copyright.