patients reported the development of a tender lump, which, being part of a systemic disease, was not confused with a carcinoma. One of the patients, however, was subjected to simple mastectomy.[1]

Hard, fixed masses in the breast suggest carcinoma. Fixation to the skin and surrounding tissues with retraction of the nipple of recent onset are all accepted features of the condition, and our patient had axillary lymphadenopathy, further substantiating the clinical diagnosis. In retrospect the generalised symptoms and unusually high erythrocyte sedimentation rate in the absence of any definite cause for this—for example, obvious secondary deposits in bone or bone marrow disease—might have suggested an underlying disease process, perhaps of rheumatic nature, but biopsy of the breast lesions would still have been required.

While the common clinical presentation of a fixed breast mass is usually due to carcinoma, this case and others reported[1-4] emphasise the importance of thorough investigations for those patients in whom additional symptoms suggesting a systemic disorder are present. Thus unnecessary mastectomy will be avoided.

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Hepatitis A in homosexuals

In the United Kingdom hepatitis B is a common cause of acute jaundice among homosexuals.[1] In the last six months we have noticed an increase in the contribution by hepatitis A to the overall numbers of outpatients with acute hepatitis or a history of recent hepatitis attending the department of genitourinary medicine at this hospital.

Methods and results

The development of sensitive radioimmunoassays to detect IgM anti-hepatitis A antibody[2] makes possible an accurate serological diagnosis of recent infection by hepatitis A virus. Over the two periods July-December 1979 and July-December 1980 we examined records and results of serological tests for all men who presented to the department with a history of acute hepatitis within the preceeding three months. Hepatitis B surface antigen (HBsAg) was detected by a sensitive solid-phase radioimmunoassay.[3] Non-B sera (HBsAg negative) were tested for IgM anti-hepatitis A antibody.

Hepatitis B was the most common cause of jaundice (table) in 1979. In contrast, over the same period in 1980 the incidence of non-B hepatitis exceeded by nearly threefold the incidence of hepatitis B. Of the 26 patients with non-B hepatitis, 24 had hepatitis A. Half of these patients were jaundiced when seen in the clinic. The illnesses were spread over the six-month period and were therefore not associated with a common source.

Incidence of hepatitis among patients with jaundice attending over the period July-December

	Hepatitis B	Non-B hepatitis	IgM anti-HAV positive
1979	4*	2	Not tested†
1980	9*	26	24

*One serum specimen tested elsewhere.
†Test not available in 1979.

Three of the 24 patients with hepatitis A had recently travelled abroad to areas where hepatitis A virus is prevalent. One of these three was a heterosexual HBsAg carrier who gave no history of a sexually transmitted illness. Twenty-three patients were homosexual (including one bisexual). They had a history of sexually transmitted diseases, 14 (61%) having suffered from gonorrhoea and 12 (52%) from syphilis. Nine (39%) had previously acquired gonorrhoea, syphilis, and hepatitis B, and only five (22%) had no history of any of these infections.

Comment

Transmission of hepatitis A is usually considered to be faecal-oral. Among homosexuals in the United States of America oral-anal contact predisposed to hepatitis A,[4] and such practices may have facilitated the infections reported here. In our experience other practices such as inserting a hand or even a fist into the partner's rectum, although not uncommon in the United States of America, are seldom admitted to in the United Kingdom. Gross faecal contamination of the environment must result from this behaviour.

There has been a steady decline in the incidence of infectious hepatitis, almost certainly hepatitis A, over the past 10 years in the United Kingdom. The slight increase in hepatitis A in 1980 (N D Noah, personal communication) is insufficient to account for the pronounced increase seen in our patients. It is possible that wider acceptance of the behaviour described above has led to the present outbreak of hepatitis A among homosexuals and that hepatitis A should now be added to the growing list of infections associated with homosexual practices in the United Kingdom.

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Proprietary depigmenting cream used wrongly for lentigo maligna

Claims that topically applied hydroquinone can reduce melanin pigmentation have a sound basis,[1] and creams containing this chemical have been available over the counter in the USA for more than 10 years and in the United Kingdom for at least two. A recent report has warned of the danger of the mistaken use of such creams in superficial malignant melanomas.[2] We describe a patient whose use of such a depigmenting cream delayed the surgical excision of a lentigo maligna for a year, allowing it to grow to a considerable size.

Case report

A 57-year-old white woman presented with a four-year history of a pigmented lesion on the left cheek. She had been brought up and spent much of her adult life in South Africa, and her skin had always burned easily in the sun. A basal-cell carcinoma had been excised from her face when she was aged 37. The lesion on her cheek had grown slowly for about two years and thereafter more quickly. She had tried various proprietary creams with little success, and for this reason had changed to a cream containing 2% of hydroquinone, available over the counter. She had persisted with this for about a year as it had undoubtedly caused some depigmentation, particularly in the centre of the lesion (figure). The lesion had continued to enlarge, however, eventually reaching 4·5 cm in diameter. A skin biopsy specimen confirmed the clinical diagnosis of lentigo maligna, and she was referred to the department of plastic surgery for excision and grafting.

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