than exposure to ultraviolet radiation may be elucidated by further study of the subgroup of patients with such cancers.

However, the development of basal-cell carcinoma in the genital area is an unusual event. Gibson and Ahmed reported a series of 51 basal-cell carcinomas in the perianal and genital regions, which made up 0.27 percent of basal-cell carcinomas at the authors' institution.[1] Furthermore, in the recent article by De Giorgi et al., the 63 cases of vulvar basal-cell carcinoma accounted for only 1.75 percent of the 3604 cases of basal-cell carcinomas at their institution during the study period.[2] De Giorgi and colleagues correctly state that vulvar basal-cell carcinoma can mimic eczema or psoriasis, as can occur in cases of superficial basal-cell carcinomas at other body sites as well. In general, patients with cutaneous diseases that fail to respond to initial therapies benefit from a skin biopsy to help confirm a suspected diagnosis or to exclude the possibility of a neoplastic process such as basal-cell carcinoma.

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Newly Diagnosed HIV Infection

TO THE EDITOR: In his article on the management of newly diagnosed human immunodeficiency virus (HIV) infection (Oct. 20 issue),[1] Hammer did not specifically recommend screening for gonorrhea and chlamydia. These often asymptomatic infections can cause disease, increase the transmissibility of HIV,[2] and result in elevated plasma levels of HIV type 1 (HIV-1) RNA and decreased CD4 cell counts.[3,4]

In a study of early HIV infection, we screened all patients with newly diagnosed HIV for pharyngeal, urethral, and rectal gonorrhea and chlamydia with the use of nucleic acid amplification (BD ProbeTec ET, BD Diagnostic Systems; APTIMA Combo 2 assay, Gen-Probe). Among 52 patients, 98 percent were men who have sex with men; the median age was 36 years (interquartile range, 30 to 40), the median plasma HIV-1 RNA level was 22,097 copies per milliliter (interquartile range, 3306 to 168,730), and the median number of sex partners during the six months before testing was three (interquartile range, two to four). We detected rectal gonorrhea in six patients (12 percent), rectal chlamydia in five (10 percent), pharyngeal gonorrhea in four (8 percent), and urethral gonorrhea in one (2 percent). Overall, we diagnosed one or more sexually transmitted diseases in 12 patients (23 percent).

U.S. federal guidelines recommend periodic screening for gonorrhea and chlamydia in HIV-infected persons.[5] The high prevalence of gonorrhea and chlamydia in our study supports the use of comprehensive screening for patients with newly diagnosed HIV infection as well.

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THE AUTHOR REPLIES: The importance of gonorrhea, chlamydia, and other sexually transmitted infections with respect to initial screening for HIV infection was noted in the article, as was the importance of the use of condoms both to prevent the acquisition of sexually transmitted infections and to promote secondary prevention of the spread of HIV-1. The list of recommended laboratory tests (which included tests for several other pathogens that can be acquired through sexual contact) did not include screening for gonorrhea and chlamydia, but it certainly could have. The consensus U.S. recommendations[1] referred to by Chin-Hong et al. and these authors' data on a population of men who have sex with men support data-driven decision making with regard to the optimal testing strategies for sexually transmitted infections in populations at risk.

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Hurricane Katrina and Disaster Medical Care

TO THE EDITOR: After reading the Perspective articles about Hurricane Katrina (Oct. 13 issue), I would like to offer another perspective. Although the public health work described in the first two articles was admirable,[1,2] it was irrelevant to most of the people who were evacuated. Only about 50,000 went to shelters. Most of the nearly 1 million displaced people went to hotels or to the homes of family and friends. Among them were the doctors and nurses who normally served this population.

Dr. Cranmer is correct about the disconnect between the needs of the hurricane victims and the aspirations of the volunteers from elsewhere.[1] The doctor she describes was a thoracic surgeon. We didn't need more thoracic surgeons or emergency-medicine physicians. What the displaced people needed from the beginning, and still need today, is access to primary care for chronic illnesses and to the medicines that keep their diabetes and chronic obstructive pulmonary disease under control. Our current medical response to disasters is designed for terrorist attacks. Our current disasters are storms, fires, and earthquakes. Medical care for chronic conditions and acute illnesses should be available to evacuees from the moment they walk into a shelter or arrive on a cousin's doorstep. The only way to provide immediate care is to use the resources that are already present and functioning. Shelter organizations like the Salvation Army and the Red Cross should enlist the services of organizations such as the American Medical Association, the American Academy of Family Physicians, and the American Hospital Association to establish a medical response as part of our disaster-relief system. We need to stop letting well-intentioned officials and volunteers shoulder aside local resources. We should coordinate the doctors and nurses who are already there to manage the response. Displaced populations in the United States need care providers who know them and their needs, speak their language, and know their culture.

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DR. CRANMER REPLIES: Dr. Rathbun is absolutely right. As was noted at the World Conference on Disaster Reduction in January 2005, "While the occurrence of natural events is largely beyond hu-

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