ween health professionals and a child health computer system for the uptake of measles immunization. Such computer systems are being set up by many district health authorities in response to the Körner report, but this barely mentioned general practice where the vast majority of primary care contacts take place. As a result we now have primary care computerization developing in three different directions. There are the district health authority systems based on Körner, the family practitioner committee computerized records for item of service payments and sometimes recall, and then the growth of microcomputer systems in general practice itself. There is as yet little communication between these three developments. It is not surprising that computerized recall systems are often unsatisfactory if only because there is no system in this country of registering changes of address. One result is that information on immunization and child development recorded by health visitors and community health clinics is often not recorded in general practitioners' notes, which are the only records which should follow that child round for the rest of its life.

Perhaps medical schools need to take note of another paper in the same volume of *Community Medicine* which highlighted the lack of management training at all levels of medical education.

(D.H.)

Sources: Russell EM. Community medicine and primary care in Scotland. *Community Med* 1988; **10:** 112-116. Morris RW, Lakhani AD, Morgan M, *et al.* The role of information flow between health professionals and the child health computer system in the uptake of measles immunization. *Community Med* 1988; **10:** 40-47. Parkhouse J, Ellin DJ, Parkhouse HF. The views of doctors on management and administration. *Community Med* 1988; **10:** 19-32.

Prostatism — early resection prevents retention

BENIGN prostatic hypertrophy is one of the disadvantages encountered by man on gaining the erect posture and it is still regarded by many as an inevitable part of ageing. Prostatism is present in up to 10% of male Caucasians over the age of 50 years, and with an increase in male longevity we should be reviewing our passive approach to this problem.

A retrospective review of patients over 60 years old in one practice showed that out of 107 with documented prostatism, 43% developed acute or chronic retention before surgery. A prospective, questionnaire-based study of 316 men in this age group in the same practice revealed 14% with mild, and 6% with marked, prostatism, based on a positive response to symptoms such as hesitancy, poor flow, dribbling, and nocturia.

Benign prostatic hypertrophy is common and rarely life threatening but it is uncomfortable and may lead to renal impairment from increasing back pressue. As transurethral resection is now the procedure of choice for benign prostatic hypertrophy, screening in general practice to enable earlier elective intervention becomes more important. This also enables the patient to be educated about reducing the disruption of lifestyle caused by urinary symptoms, such as the need to avoid retention, the risks of excess alcohol consumption, and voluntary delay in micturition.

Future management of prostatism should be anticipatory with early elective surgery rather than waiting for the progress of symptoms such as retention.

(C.D.)

Source: Steyn M. Just old age? A study of prostatism in general practice. *Fam Pract* 1988; **5:** 193-195.

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INFECTIOUS DISEASES UPDATE: AIDS

● A European study group looking at sexual transmission of the human immunodeficiency virus (HIV) from infected men to their female partners identified three significant risk factors: a history of sexually transmitted disease in the previous five years for the female partner, the practice of anal intercourse, and the index patient having acquired immune deficiency syndrome (AIDS).[1] Couples with none of these risk factors had a 7% chance of seroconverting while those with two or three had a 67% chance. The overall rate of transmission was 27% (42/155).

Regardless of the duration of the relationship or the frequency of sexual contact, men with AIDS seemed to be more infective than asymptomatic carriers. It is likely that in a city such as Edinburgh, where there are large numbers of heterosexuals infected with HIV and as yet few cases of AIDS, there is the potential for a major epidemic of sexually transmitted infection.

● A 17-year-old Parisian male who had never injected drugs, had sexual intercourse or had a blood transfusion, presented with symptoms of acute HIV infection following a six-week course of acupuncture treatment for tendinitis.[2] This is only the third reported case attributable to this mode of transmission. Such cases although rare are likely to have resulted from the inoculation of relatively small amounts of blood and clearly remind us of the dangers of underestimating the infectivity of the human immunodeficiency virus.

● A consultation on AIDS and sport convened by the World Health Organization and the International Federation of Sports Medicine has concluded that there is no medical or public health justification for testing or screening athletes for infection with HIV prior to participation in sports activities. Indeed, as yet there has been no documented instance of transmission of HIV through sporting involvement.[3]

● At the end of 1988 a total of 9603 cases of HIV antibody positive persons had been reported to the CDSC and the CD(S)U. Of these, 71% had been reported by units in the Thames region and in Scotland, indicating the main HIV 'hot spots' in the UK.

Regarding AIDS, 2049 cases had been reported by 31 January 1989 of which 1089 had died. This compares with a total of 139 886 cases of AIDS from 144 countries reported to the World Health Organization in Geneva over the same period.

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3. World Health Organization. Consultation on AIDS and sport. *CDS Weekly Report* 89/07 (A90).

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