parents given smoking advice were as a result of the child suffering with acute otitis media. In addition, we could only identify parents who were registered with our practice. There was no way of including adults in the home who were not parents or guardians.

This audit was presented to the partners, and a plan was made to put up reminders to discuss smoking with the parents of any children presenting with acute otitis media. The audit is to be repeated in 1 year to allow sufficient numbers of cases to present.

We realise that this is just one of many motivational factors that can be used to encourage patients to stop smoking, but smoking cessation is such a high priority that this window of opportunity should not be overlooked. Prevention rather than prescriptions must remain our ideal in the management of otitis media.

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How can we remove barriers to HIV testing outside of a GUM setting?

Approximately 32% of patients infected by HIV in the UK remain undiagnosed.[1] Delayed HIV diagnosis is responsible for HIV presentation at lower CD4 T-cell count and such patients respond less well to antiretroviral therapy.[2] At least 35% of HIV-related deaths in 2005/6 in the UK were attributed to late diagnosis of infection.[3] Furthermore, delays in HIV diagnosis and initiation of antiretroviral therapy contribute to horizontal and vertical transmission of HIV infection.[4,5]

A recent study examined the factors which were significantly associated with GUM clinic patients (not exclusively attending for HIV testing) agreeing to GP contact. These factors included heterosexual orientation, initial GP referral, and not considering HIV testing to have negative implications for future mortgage and life insurance applications.[6]

Two factors have been reported to us that impair the ability of non-genitourinary practitioners, both in primary care and other specialist care settings, to perform HIV testing. The first is pre-test counselling. We would argue that, as in other disease areas, the pre-test counselling is no longer necessary as there are clear health benefits in knowing about an HIV diagnosis which outweigh perceived disadvantages. This is consistent with a general move towards 'opt out' HIV testing in GUM clinics and antenatal services.[7] In rare, high risk, or acutely unwell cases, pre-test counselling may be the preferred option, but for the majority of patients it is not required. The second barrier cited is that of transparency about HIV testing for insurance company medical reports. However, the GP and insurance applicants are not required to notify insurers when negative tests are performed.[8]

The life expectancy of a 25-year-old HIV-positive person, who is hepatitis C negative, has been estimated to be greater than 35 years[9] and this will increase as newer anti-retroviral drugs become available. Like other chronic and manageable conditions, an early diagnosis is essential to maximise individual and community health but this can only be achieved by the removal of barriers to widespread HIV testing across all hospital departments and primary care. We urge that the earlier diagnosis of HIV infection is made a clear priority and that the role of specialist genitourinary clinicians to enable better training, clear referral pathways, and the destigmatisation of testing in all care settings are key parts of the development of local sexual health networks.

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Benzodiazepine tolerance, dependency, and withdrawal syndromes and interactions with fluoroquinolone antimicrobials

I investigated reports of an abnormally high incidence of adverse reactions to