3 Lester E, Grant AJ, Woodroffe FJ. Impotence in diabetic and non-diabetic outpatients. *BMJ* 1980;281:354-5.
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Two drugs are better than one

EDITOR,—We disagree with some of D E Price's views on managing erectile dysfunction in diabetes.[1] The erectile dysfunction is not always organic in origin since psychogenic factors based on anxiety are as common in diabetic patients as in the general population. A total lack of erections under all circumstances, including during sleep and on waking, may indeed be due to neurogenic impotence, but patients with this are a minority. Patients more commonly complain of a partial erection during sexual activity, which suggests a vasculogenic rather than a neurogenic cause.

Intracavernous injection of a vasoactive agent is a simple means of distinguishing vasculogenic from psychogenic and neurogenic impotence. More sophisticated investigations are rarely necessary except to investigate the possibility of occult neurological problems or of arterial disease worth treating surgically—that is, in young non-smoking men under 40 who do not have diabetes or hypertension. The use of intracavernous agents for erectile dysfunction has indeed revolutionised the management of this problem, but, at least in theory, papaverine should not now be used alone because of the occurrence of penile fibrosis and priapism. The incidence of these complications is diminished by the addition of phentolamine, but prostaglandin E_1 is safer, although a suitable formulation for general use is not yet available.

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1 Price DE. Managing impotence in diabetes. *BMJ* 1993;307: 275-6. (31 July.)

Wait to be asked before offering advice

EDITOR,—I support D E Price's view that assessment and treatment of impotence should be part of the routine of a diabetes care service.[1] Unless general practitioners and diabetologists take an active interest in this problem highly effective treatments will remain unavailable to most NHS patients. An analysis of patients (n=258) at the diabetes clinic where I work has shown that, after discussion, 77 decided not to progress to physical treatments, 124 chose self injection treatment, 31 chose vacuum devices, and 26 required referral for specialist urological or psychological treatments.

The general practitioner should be prepared to discuss the problem, put it into perspective, explain causes and possible treatments, and refer only if physical treatments are required. The diabetologist, who knows the patient, is then well placed to provide, on the NHS, initial treatments such as injections with vasoactive drugs or vacuum devices. Urologists and specialist psychosexual counsellors can then devote their time to people with specific problems.

I would caution against direct questioning about erectile dysfunction during the patient's annual review unless the service can cope: such questioning is likely to lead to an unmanageable workload. I have found that only 18% of patients identified by a screening questionnaire as having erectile dysfunction ultimately opted for physical treatments, whereas 88% of those who spontaneously volunteered the problem did so.[2] All doctors have limited time and resources, and efforts should be concentrated on those who volunteer the problem.

I no longer use test doses to assess the response to self injection treatment. Instead I show people the technique and reassure myself that they can perform it safely and then give them a suggested incremental dose regimen to try at home so that they find the lowest dose that produces a sufficient response. Thus prolonged erections are avoided. This method also reduces the need for follow up as everything can be achieved at a single appointment; thus time can be dedicated to new referrals.

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1 Price DE. Managing impotence in diabetes. *BMJ* 1993;307: 275-6. (31 July.)
2 Alexander WD. The diabetes physician and an assessment and treatment programme for male erectile impotence. *Diabetic Med* 1990;7:540-3.

Community health doctors left out

EDITOR,—Martin Harris writes that he believes that community health doctors are being subtly written out of the script of medical politics.[1] He could well be correct in that there is now little affiliation between community health and public health medicine. Another solution is possible. The days when the vista of hospital consultants was only as far as the perimeter of their establishment is over and, for example, community paediatrics is well integrated into hospital practice in many areas of the country. Other community health doctors can similarly find advantageous liaison with clinical consultants rather than with public health medicine.

The fact that there still remains a separate BMA public health medicine committee is anachronistic, hearkening back to when the medical officer of health was a local government employee with vastly different terms and conditions of service to other salaried doctors in the health service. Management responsibilities pervade the work of most consultants, so one wonders why there is a need for a separate committee. Before the 1974 reorganisation, administrative medical officers of regional hospital boards were under the purview of the Hospital Consultants' Committee, and the integration of the CCSC and the CCPHM and CH might be more in keeping with the political demands of the modern NHS. Now that Dr Harris has triggered the concept I will see, with the help of my colleagues, if a national debate on this aspect of BMA committee structure can be initiated.

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1 Harris MTM. Community health doctors left out. *BMJ* 1993; 307:328. (31 July.)

Medical courses in the Czech Federal Republic

Ask the GMC before applying

EDITOR,—Richard Tranter describes a scheme whereby British students who have failed to gain places at medical schools in Britain may be able to study medicine in the former Czechoslovakia.[1] Potential students should be aware that there is no guarantee that the courses will be acceptable for registration in Britain by the time they graduate.

Tranter's article also implies that the Czech and Slovak Republics are likely to become full members of the European Community in the near future. This is misleading. Although they have close links with the European Community, they are unlikely to achieve full membership in the next few years. Until they do, graduates from their medical schools who want to practise in Britain will be expected to sit the Professional and Linguistic Assessment Board's test. Furthermore, any British graduate of a Czech university practising in Britain after passing the linguistic test would be excluded from the terms of the doctors' directives (93/16/EEC) and would not, under current European Community law, have the automatic right to free movement within the community.

The international department of the BMA has received many inquiries from students who narrowly missed achieving the A level grades required for entry to British medical schools and see the courses offered by the Czech universities as an attractive solution to their problems. I advise all such applicants to contact the General Medical Council for advice before making their decision.

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1 Tranter R. UK students offered Czech medical training. *BMJ* 1993;307:584. (4 September.)

Registration lasts only five years

EDITOR,—Richard Tranter's article on how universities in the former Czechoslovakia are offering medical training to British students[1] corrects misreporting elsewhere. Most readers of the *BMJ* will understand the significance of Tranter's reference to a Czech medical degree having limited recognition with the General Medical Council. But, because his article may be seen and acted on by others not familiar with the system, I wish to put on record that these qualifications are accepted for limited registration only. Such registration is limited by law to a maximum of five years and can be exercised only in supervised employment in hospital posts that are educationally approved for training purposes. Also, before obtaining limited registration, doctors have to pass (or be exempted from) the Professional and Linguistic Assessment Board's test, entry for which entails completion of 12 months' clinical work overseas. Doctors with limited registration may be able to proceed to full registration, but that is by no means a foregone conclusion.

The acceptance of these qualifications is currently under review, partly because of anxieties about the difficulties of giving satisfactory clinical training to English speaking students, characterised by the example in the article. The General Medical Council has asked for further information about several matters; when it has received this information it will decide whether the degrees should continue to be accepted.

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1 Tranter R. UK students offered Czech medical training. *BMJ* 1993;307:584. (4 September.)

Correction

Prevention of melanoma in Torbay

An error occurred in this letter by Judy Evans (7 August, p 379). The first sentence of the fourth paragraph should read: "Members of the team approached over 1700 beach users [not 17 000] as they passed or neared the stand we had set up."

No money, no treatment

An author's error occurred in this letter by Jackie Ketley (5 June, p 1544). The patient reported on had previously attended the emergency dental clinic at Guy's Hospital, not at the Royal London Hospital as stated.