travel, and hold down a job. Such patients were maintained for long periods on reasonable doses which did not need increasing. Disabling anxiety often returned if the dose was reduced, which is not surprising in patients suffering from those particular chronic illnesses.

Further distress is now occurring in this chronically anxious, and therefore vulnerable, group of patients as a result of the damnation chorus. While the benzodiazepines may be far from ideal, there is still a large population needing treatment for anxiety. This may have to be in the form of medication, even if only because the sheer weight of their numbers makes other forms of treatment unavailable.

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Compulsory HIV testing in psychiatry

SIR: The Royal College of Psychiatrists' guidelines for the management of HIV-related conditions in psychiatric practice were published recently (Catalan *et al*, 1989). The *British Medical Journal* commented that perhaps the most controversial point in the guidelines refers to the legality of testing without consent (*British Medical Journal*, 1989). The question, however, extends beyond the framework of the current legislation. The 1983 Mental Health Act was drawn up at a time when the HIV test was not yet available and the HIV epidemic was not a major issue on the British agenda. It would be wrong to use such legislation to support controversial clinical procedures which should be primarily driven by ethical, social, and clinical considerations. In the light of this *Journal's* coverage of these issues to date, I will concentrate on the points which merit further discussion.

1. Placing an emphasis on education and confidentiality when dealing with HIV in psychiatric practice is not an easy option, but is a challenge which could be met with alacrity. It is as well to ask how many psychiatric hospital wards give regular education programmes on AIDS-related risk behaviours to staff and patients, and how many provide ready access to condoms? In the face of staff prejudices, their knowledge of a patient's serostatus can lead to worse rather than better patient care (Cummings *et al*, 1986).

2. A difficult dilemma might arise in the future when AIDS-related dementia is suspected in a patient, now that treatment with zidovudine has become an experimental option (Schmitt *et al*, 1988). The evidence at present does not justify compulsory HIV testing and treatment with zidovudine in this condition.

3. I do not believe that HIV testing should be carried out without consent in patients showing aggressive or uninhibited behaviour. From the point of view of the patient, the financial, social, and occupational implications of an HIV test are enormous. Perhaps these need to be further spelt out to proponents of compulsory testing. It has been known in the past, for example, for an insurance company to penalise a candidate for having had an HIV test, whatever the result. From the point of view of staff safety, a negative result could "lull (them) into a false sense of security", as Dunn (1988) has already pointed out. A negative HIV Ab test can result not only from the sometimes lengthy period to seroconversion, but also from the finite specificity of the tests. It is important, therefore, to ensure staff safety by the provision of adequate numbers of trained staff and protective equipment.

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Delusions of pregnancy in men

SIR: We read with interest Chaturvedi's report (*Journal*, May 1989, **154**, 716–718) of delusions of pregnancy in men. We describe below a patient with delusions of multiple pregnancy and multiple births where, unlike Dr Chaturvedi's case, no obvious organic pathology seemed to account for this symptom.

Case report: A never married, 31-year-old caucasian male with a 15-year history of chronic undifferentiated schizophrenia was admitted for in-patient evaluation after having failed to respond to adequate trials of three different neuroleptic drugs. He had also developed intolerable symptoms of akathisia and dystonia. All neuroleptic drugs had been discontinued one week prior to admission. Propranolol (80 mg/day) and lorazepam (1.5 mg/day) were discontinued over a period of 7 days after admission.