patients reported by Groves *et al.* They show, in any case, remarkable similarities in relation to the location of the block within the atrioventricular node. They all had a wide QRS which suggests a distal block within the bundle of His. Groves *et al* performed a pathological examination of the hearts of their patients and demonstrated a distal lesion of the bundle of His of the type of nodoventricular block instead of atrioventricular block.[2] This is in accordance with the pathological findings of Ho *et al*,[3] and with the clinical data presented by Frohn-Mulder *et al*[4] who noted that the QRS width was wider in a group of anti-Ro negative patients compared with a group of anti-Ro positive children.

Pathogenic mechanism of isolated congenital heart block has been related to immune mechanisms mediated by anti-Ro or anti-La antibodies. Immune mediated damage is usually located proximal to the bundle of His. Damage of the conduction system in anti-Ro negative patients seems to be located distal to the bundle of His. This may explain a lower ventricular rate which could explain the poor outcome of Groves *et al*'s patients. Further serological and familial studies of anti-Ro negative patients may give insight into the mechanism of the disease.

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1 Groves AMM, Allan LD, Rosenthal E. Outcome of isolated congenital complete heart block diagnosed in utero. *Heart* 1996; 75:190–4.
2 Lev M, Silverman J, Fitzmaurice FM, Paul MH, Cassels DE, Miller RA. Lack of connection between the atria and the more peripheral conduction system in congenital atrioventricular block. *Am J Cardiol* 1971;27: 481–90.
3 Ho SY, Essher E, Anderson RH, Michaelsson M. Anatomy of congenital complete heart block and relation to maternal Anti Ro antibodies. *Am J Cardiol* 1986;58:291–4.
4 Frohn-Mulder IM, Meilof JF, Szatmari A, Stewart PA, Swaak TJ, Hess J. Clinical significance of maternal anti Ro/SSA antibodies in children with isolated heart block. *J Am Coll Cardiol* 1994;23:1677–81.

CORRECTION

Impact of the 1991 NHS reforms on the availability and use of coronary revascularisation in the UK (1987–1995)
Black N, Langham S, Coshall C, Parker J. Heart 1996;**76(suppl 4)**:1–31.
Data on the availability of whole-time equivalent (WTE) adult cardiac surgeons in Glasgow in 1994–95 was incorrect. There were 5·9 (not 10·9) WTE representing 3·38 (not 6·25) WTE per million population aged over 24 years (Appendix 1, page 25; fig 10, page 8). The comments on page 9 should read:
Consultant levels more than doubled in East Anglian, though the increase in South East Thames was only 27%, in Greater Glasgow only 22% and there was no increase in North Western (fig 10).
Similarly, the fifth statement on page 22 under *Objective 1* should read:
The availability of consultant surgeons showed little or no change between 1987 and 1995 in three regions but more than doubled in East Anglian.

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NOTICES

The First European Workshop on Hypertrophic Obstructive Cardiomyopathy under the auspices of the Working Groups on Myocardial Function and Cardiomyopathy of the European Society of Cardiology will take place on 31 October 1997 at the Imperial College School of Medicine, London, UK. Course fee (includes coffee, tea, lunch, and live teleconference) is £125. For further information please contact The Conference Centre (tel: 0171 351 8172; fax: 0171 376 3442; email a.c.allen@ac.ic.uk).

Practical Adult Cardiovascular Pathology Course will take place on 17 November 1997 at the National Heart and Lung Institute, London, UK. Course fee (includes coffee, tea, and lunch) is £125; £100 for juniors in training. For further information please contact National Heart and Lung Institute (tel: 0171 351 8172; fax: 0171 376 3442).