capable of producing both superoxide and hydrogen peroxide with the reintroduction of the blood supply.[5] Dr Murrel and his colleagues have found that the xanthine oxidase inhibitor allopurinol is of benefit in Depuytren's contracture.[6] Although this trial was uncontrolled we have been unable to find reports of spontaneous resolution in published reports. It would be of interest to establish whether allopurinol supresses the destructive consequences of inflammatory tenosynovitis associated with rheumatoid disease.

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The natural course of gold nephropathy

SIR,—We would like to clarify the points raised by Drs John A Hunter and Hilary A Capell (21 November, p 1350) concerning our study of the natural course of gold nephropathy (26 September, p 745). The criterion for nephrological referral was persistent proteinuria in excess of 0·3 g/l (in the absence of urinary infection) that developed during gold treatment. Twenty two patients fulfilled this criterion, and in only one patient, who was shown to have amyloid, was a disease other than gold nephropathy shown by renal biopsy.

We strongly recommend that all patients with rheumatoid arthritis and proteinuria should be investigated fully and that renal biopsy should be carried out, if indicated, to provide a precise diagnosis permitting appropriate treatment and accurate prognosis. In more than 90% of patients who develop proteinuria during gold treatment, however, the drug is the cause of the proteinuria, which resolves when treatment is stopped. In these particular patients and circumstances, provided that the results of relevant tests for causes of proteinuria other than gold nephropathy are negative, the proteinuria resolves within one to two years of gold treatment being stopped, and renal function does not deteriorate, renal biopsy seldom contributes to the management of the patients and is unnecessary in routine clinical practice.

We agree that effective treatment for the rheumatoid arthritis needs to be continued but suggest that, to avoid confusion, a drug which does not cause proteinuria should be given until the gold induced proteinuria has resolved. Thereafter penicillamine, particularly in low dosage, is a suitable treatment. The prescriber should, however, be aware of the increased incidence of proteinuria during penicillamine treatment in patients with rheumatoid arthritis who have a history of gold induced proteinuria.[1]

With regard to the role of corticosteroid treatment, our results indicate that gold nephropathy resolves without such treatment and we were able to manage several patients with severe proteinuria (15-31 g/day) with dietary and diuretic treatment. Continuing proteinuria of this severity, however, particularly when associated with profound hypoalbuminaemia, deteriorating renal function, and threatened acute renal failure, might be an indication for short term high dose corticosteroid treatment either alone or in combination with other immunosuppressive agents, and I am pleased to supply the reference for this.[2]

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Contraceptive services for ethnic minorities

SIR,—We disagree with Dr Jon Fuller's suggestion that "in an ideal world people would receive contraceptive advice . . ." (28 November, p 1365). In contraception one does not give advice: one listens to the patients' needs, likes, fears, and worries and helps them to come to a decision on the best method of contraception for them. Any other course is at worst patronising, at best useless.

The implication in his article is that language is the basis of his definition of "ethnic minority." Our experience over the past 20 years in clinic and domiciliary contraceptive services in Sheffield leads us to different conclusions about patients whose first language is not English. The most important issue to such patients is exactly the same as to a native English speaker: to achieve as direct contact as possible with the doctor in whom they have confidence. A consultation in very rudimentary English (and it is surprising how far a very few words will sometimes stretch) is usually preferred to a discussion through an interpreter. It is not uncommon for patients to express a preference for a consultation with an English doctor, in English, over a consultation with a doctor of their own race.

The proposal to use "patients' advocates" seems potentially disastrous. Such an expert, informed, fluent, and therefore inevitably dominant person would erect an impenetrable barrier between doctor and patient and often would present to the doctor his or her own "interpretation" of the wishes of the patient. At our largest clinic 20% of patients are Roman Catholics. Had their interests been represented by someone who interpreted "the patients' needs and beliefs and provided an insight into the current beliefs of that community" we suggest that many thousands of patients would have been very dissatisfied with the service that we would have provided under the mistaken belief that it was what the patient wanted.

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Treatment of cardiac arrest by ambulance staff

SIR,—We support the view expressed by Dr J A Rowley and others (28 November, p 1387) regarding advanced cardiac training for ambulance staff. The major determinant of survival from out of hospital cardiac arrest is prompt defibrillation.[1 2] There would therefore be greater life saving potential from making defibrillators widely available than from the more extensive training of a smaller number of ambulance crews.

The training programme described, however, required 96 hours.[3] This may still be too lengthy a commitment for some ambulance services if many staff are to be trained. Hospital attachment, monitoring of individual rescuer's performance, and refresher training add constraints to developing and maintaining prehospital definitive cardiac care programmes.

Since October 1986 we have been coordinating a trial using semiautomatic advisory defibrillators in south east London. Two hundred ambulance staff underwent a six hour training programme and all completed the course satisfactorily. Preliminary analysis of our results indicates that the machine is sensitive and specific for ventricular fibrillation and that ambulance crews are using the defibrillator correctly according to the protocol. Hospital attachment, delays in recognising arrhythmias, and retraining are not problems. Previous work comparing automatic external defibrillators with conventional manual defibrillators has shown that they are equally effective at terminating ventricular fibrillation.[4]

This training could be easily included in basic ambulance training, thereby maximising the provision of prehospital defibrillation and avoiding delays associated with more expensive and extensive cardiac training.

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Sequential hormonochemotherapy in advanced breast cancer

SIR,—The excellent response rate to cyclical sequential hormonochemotherapy in metastatic breast cancer reported by Mrs Ghilchik and associates (7 November, p 1172) is exciting.

The article does not specify, however, whether these patients had received any previous hormonal treatment or chemotherapy, either as adjuvant treatment or for earlier relapses. No data on the oestrogen or progesterone receptor states of their tumours is given, but we may assume that since all but two were postmenopausal, with a mean age of 63 years, most were oestrogen receptor positive.[1]

In a small series of patients such as this it is not possible to show that sequential combination therapy has significantly improved the response rate over either hormonal treatment or chemotherapy alone. Hormonal treatment may give up to a 70% overall response rate in patients who are both oestrogen and progesterone receptor positive.[2] Cyclophosphamide-methotrexate-fluorouracil chemotherapy regimens will give response rates of 50 to 80% in non-pretreated patients, which has been reproducible across several series.[3]

It is not possible, therefore, to discern from the results of this study whether the combination was truly better than either of these two treatment

approaches used alone. Clearly a randomised trial including larger numbers of patients is a necessity. In that regard, the results of a recent study by Lipton *et al* failed to show that oestrogen priming increased the response rate in patients treated with aminoglutethimide and chemotherapy.[4]

Sequential hormonochemotherapy makes sense based on in vitro data and is certainly an intriguing concept in cancer therapy. It has appeared to be efficacious in a succession of small non-randomised trials, but very little in the way of cell kinetic data in the tumours thus treated has been forthcoming. I believe that it is time to proceed with larger randomised trials of chemotherapy with and without hormonal priming in an attempt to obtain in vivo cell kinetic data in those patients with accessible tumours.

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Management of retinal vein occlusion

SIR,—Dr Paul M Dodson and Mrs Erna E Kritzinger (5 December, p 1435) do not mention the role of anticardiolipin antibodies in thrombosis.

Anticardiolipin antibodies, and the other antiphospholipid antibodies, the lupus anticoagulant, and the false positive serological test for syphilis, are associated with both venous and arterial occlusion.[1 2] In the unusual syndrome of occlusive ocular vascular disease complicating systemic lupus erythematosus retinal arterial and venous thrombosis and choroidal infarction have been observed[3] and anticardiolipin antibodies have been described in such patients.[4] Anticardiolipin antibodies have also been found in arterial and venous thrombosis in various anatomical sites in the absence of systemic lupus erythematosus or any other autoimmune disease.[5] The presence of the lupus anticoagulant has also been documented in young patients with idiopathic cerebrovascular disease.[6] Significant titres of anticardiolipin antibodies were found in 21% of patients with acute myocardial infarction aged under 45 who similarly had no other evidence of autoimmune disease.[7]

Because of these associations of anticardiolipin antibodies with idiopathic thrombosis many ophthalmologists may consider measuring anticardiolipin antibodies in patients with occlusive retinal vascular disease. We studied a group of 40 patients who presented with retinal vascular occlusion of recent onset in the absence of systemic lupus erythematosus or other autoimmune disease.

Thirty seven patients had retinal vein occlusions and were examined for the presence of raised intraocular pressure and intraocular inflammation as well as for the known systemic risk factors for thrombosis. An additional three patients with idiopathic retinal arterial occlusions were added after detailed studies had excluded any source of emboli or arteritis.

Twenty six (65%; mean age 67 years) patients had one or more recognised risk factors; 14 (35%; mean age 51) had none; the second group was younger and included the only five patients under 40. All 40 patients were negative for antinuclear antibody and lupus anticoagulant, had a negative result on the Venereal Disease Research Laboratory test, and had no antibodies to cardiolipin.[8]

Thus anticardiolipin antibodies seem to be important in retinal vascular occlusion only in the presence of systemic lupus erythematosus. They are not a feature of idiopathic retinal vascular thrombosis and should be looked for only if the retinal thrombotic event occurs in a patient with systemic lupus erythematosus.

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Obstetricians on the labour ward

SIR,—Dr J S Samra and others (12 December, p 1566) express surprise that consultants in a two tier unit went into hospital at night on an average of only 3·5 times per month. It may not be clear from the article by Dr V A Coupland and others (24 October, p 1077) that this refers to the hours between midnight and 8 00 am. There would be many other visits between 6 00 pm and midnight. Anyhow, these data were collected over just a short time and are related strictly to a given workload and the ability of the senior house officer on duty at the time.

Dr D J Houghton (12 December, p 1568) obviously fears a "downgrading" of the consultant role. If a consultant is regarded as a remote figure delegating the technical work to others then it is a downgrading. But what is wrong with manual dexterity? Musicians and artists seem to be quite proud of it. More anomalous is the usual position in the United Kingdom of a highly trained specialist who gives up obstetrics when he or she obtains a consultant post.

Dr Houghton's other point I can answer only empirically. In fact it does work to live, usually, at home. The only real split second emergency that needs someone on the spot is shoulder dystocia, and a good midwife can deal with that as well as we can.

I humbly suggest that there is a major issue here. The birth of a baby is possibly the main event in a woman's life. We cannot go on allocating all labour ward management to junior staff. The problem is soluble and is a matter of staffing ratios and not status and delegation.

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Time to stop putting the clocks back?

SIR,—Dr J G Avery (19-26 December, p 1586) suggests the advantages of reintroducing British Summer Time next year and quotes a figure from the Royal Society for the Prevention of Accidents of 580 as the number of road accidents likely to be prevented if British Summer Time were maintained all year. It is almost identical with the figure, 579, produced by the Pedestrian Association on Road Safety in 1970 after two years of British Summer Time and attributed by many to the new system of continuing summer time throughout the winter.

In the parliamentary debate on British Summer Time this figure and its source were quoted widely.[1] It was no doubt correct, but a resounding free vote against British Summer Time showed that a large majority attributed the reduction not to British Summer Time but to the simultaneous introduction of the breathalyser, a massive road safety programme, and the increasing number of seat belts fitted to cars.

In the same debate members of parliament described the many other accidents which increased during the summer time period: to farmers, delivery workers, milkmen, and building workers on dark, icy mornings, the doubled accident rate among postmen, and the millions lost by building firms.

The Pedestrian Association admitted that there was an increase in serious and fatal child accidents; after all, in winter summer time they had to walk to school in darkness (even worse on unlit country roads) at peak traffic periods; under Greenwich Mean Time they go to school in daylight and return in daylight.

If attributing a reduction of 579 road accidents to two years of British Summer Time was shown to be unscientific in 1970 the forecast of a reduction of 580 due to British Summer Time over one year is even less convincing.

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1 British Summer Time. Orders of the day. *House of Commons Official Report (Hansard)* 1970 Dec 2:1331-1422.

SIR,—In setting out the case for maintaining British Summer Time in the winter Dr J G Avery has drawn on the research in which I am currently engaged. He cites some of the health advantages listed in the interim report of my study. However, he has effectively played down the full advantages likely to stem from putting the clock one hour ahead of its current setting in the summer as well as the winter by stating that "the Policy Studies Institute has *even* presented the case for double summer time" (my italics). His letter suggests that its adoption, in combination with winter summer time, is unlikely to be entertained by the government, whereas it is currently under consideration.

In fact, the extra hour of evening daylight from April to September, resulting in sunset at 10 pm instead of 9 pm, 9 pm instead of 8 pm, 8 pm instead of 7 pm, and so on, would clearly have more health enhancing effects than the extra hour of late afternoon daylight from October to March. Moreover, only one of more than 200 organisations contacted for their views on this option has foreseen any disadvantage with double summer time, and most have indicated that they would welcome it.

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