told the results of tests for the human immunodeficiency virus and this reluctance might extend to other negative findings at commercial health checks. I cannot be alone in having been asked by patients not to record certain facts in their notes or their spouse's notes or to delete records of previous events, usually terminations of pregnancy.

If commercial organizations wish to obtain medical information they should arrange for independent medical interviews with examination and investigation as they see fit. We should not risk the breakdown of doctor–patient relationships for the sake of a cheque for £11.

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Azapropazone in the treatment of gout

Sir,

I read with interest the article by Fraser and colleagues (September *Journal*, p.409) on the use of azapropazone in the treatment of gout. The suggestion that monotherapy is effective in both treatment of the acute attack and as a long term agent for lowering the serum urate level will, no doubt, tempt many doctors to use this simplified regimen as first line therapy in the future.

However, I would like to sound a caveat from the authors' own results. First, 11 of the original azapropazone group were withdrawn from the study because of adverse gastrointestinal reactions — a dropout rate of 24% — despite exclusion of patients with a past history of peptic ulcer disease. One third of these were after day 28 and one patient developed a potentially fatal perforated peptic ulcer on day 85.

Secondly, there is no significant difference between the azapropazone and allopurinol treatment groups in the attack rates for gout from day 85 onwards suggesting that the observed reduced number of attacks is solely a feature of the uricosuric property of azapropazone as compared with indomethacin.

It would seem sensible, therefore, to maintain allopurinol as first line prophylaxis of gout as it is a well tolerated effective agent, with little risk of producing a fatal side effect.

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Sir,

There are several problems in interpreting the trial by Fraser and colleagues (September *Journal*, p.409) purporting to compare azapropazone with indomethacin plus allopurinol in the management of acute gout.

Allopurinol precipitates gout so a non-steroidal anti-inflammatory drug is always used for a few weeks when treatment is started. In this trial indomethacin was withdrawn when allopurinol was started so it is not surprising that there were more attacks in the group treated with indomethacin followed by allopurinol. This point is acknowledged in the text but the summary contains the misleading statement 'Fewer breakthrough attacks of gout occurred in the azapropazone group..' It would perhaps have been more in accord with current clinical practice to have continued the indomethacin when allopurinol was started, as the title of the paper suggests.

Azapropazone was said to be 'superior' to indomethacin with regard to lowering serum urate. Again this statement is misleading since lowering the serum urate is of no importance in treating acute gout. The authors themselves showed no significant difference between indomethacin and azapropazone in the first month of treatment despite much lower serum urate in the azapropazone group.

Many general practitioners would not start urate lowering treatment after a single attack of gout because the patient may not suffer another attack for months or years. When long term prophylaxis is considered necessary a non-steroidal anti-inflammatory drug is more likely to cause adverse effects than allopurinol. In this study two patients taking allopurinol were withdrawn from the trial because of unwanted effects compared with 10 taking indomethacin and 12 taking azapropazone.

This study has not demonstrated any advantage of azapropazone over other non-steroidal anti-inflammatory drugs in treating acute gout and it would not seem to be a drug of choice for prophylaxis. Was the trial sponsored by the makers of azapropazone? If so this should have been clearly acknowledged.

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Practice nurses

Sir,

We read with interest the article by Greenfield and colleagues on practice nurses (August *Journal*, p.341) but were concerned that practice nurses in the sample were undertaking tasks for which they may not have received the appropriate training.

The paper states that 21% of the sample of 300 nurses were trained midwives and 8% had a family planning certificate, but 36% were giving family planning advice, 71% were performing cervical smears and 60% speculum examination of vagina and cervix. These skills are taught on the English National Board (ENB) course 900/901–family planning nursing.

In addition, 11% of the sample were performing bimanual examination of uterus and adnexae, 18% intrauterine device removal and 62% examination of breasts. These skills are not covered by the ENB course 900/901, and are usually only performed by those nurses who have undertaken an advanced course in family planning and have the appropriate indemnity insurance cover.

Our concerns are for:

— The professional accountability of nurses who may be practising outside the UKCC Code of Professional Conduct. We would draw particular attention to numbers 1–4 of the code (2nd edition).

— The personal accountability and legal implications for the nurse concerned.

— The patients who may receive information, advice and screening from inadequately trained nurses.

— The general practitioners whose professional reputation is reflected by the standards of their practice personnel.

Family planning is a recognized specialism in nursing with its own programme of preparation and refreshment. It is essential for nurses involved in these tasks to hold the current ENB course 900/901 Certificate of Competence in Family Planning Nursing. Indeed, the steering group who reported on the training needs of practice nurses endorsed this view.

In view of the practice nurses' desire to be less task-centred it is of interest that the revised course curriculum places considerable emphasis on the development of counselling skills and health promotion in relation to fertility and sexuality. The course is open to registered nurses, midwives and health visitors. Details of training centres can be obtained from ENB, Victory House, 107 Tottenham Court Road, London W1P 0HA.

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