identified in the age group. Of these, 33 were on digoxin for atrial fibrillation. During the one-year study period, 795 patients were screened opportunistically for irregular pulse. Of these, 26 were diagnosed as having atrial fibrillation. Therefore, a total of 59 of the 828 patients screened were identified as having atrial fibrillation a prevalence of approximately 7%.

In order to maximize the benefit to risk ratio, the study protocol required one of three other risk factors to be present in order to initiate warfarin treatment.[2] These were age over 75 years, heart failure, diabetes, and hypertension. Patients not in this higher risk group were offered aspirin treatment. Some patients were excluded at this stage because of other medical conditions, such as dementia (which precluded informed consent and effective monitoring), or social conditions, such as remote location with no transport available.

Of the 59 patients with atrial fibrillation, 18 were invited to be assessed for warfarin treatment. Of these, only three agreed and actually started treatment; six others elected to take aspirin instead, and six patients were already taking aspirin. The number of patients eventually treated with warfarin was surprisingly small and may reflect transport difficulties in this rural practice.

While the study is not yet complete, our data suggest that the numbers of additional patients both requiring and agreeing to treatment and regular monitoring may not be as great as anticipated by Rodgers *et al.*

ELERI RODERICK
JIM COX

The Surgery
Caldbeck
Wigton
Cumbria CA7 8DS

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Sore throat

Sir,

We read with interest the paper by Howe (May *Journal*) regarding the resolution of sore throat symptoms following antibiotic prescription.[1] Penicillin was not found to be superior to placebo, which supports the evidence of marginal benefit of penicillin in sore throat.[2] The well-described deficiencies of throat swabs might lead one to anticipate the failure of a positive result to predict response to antibiotic treatment rather than the explanation being the efficacy of cephalosporins in patients with a negative swab.[3]

The study raises important questions about the possible benefit of cefixime. However, we would urge caution on three counts. First, what is the clinical value of a reduction in score of 3, in a composite score, on the third day of treatment? Furthermore, significance figures are not given for the differences between the groups on days 2, 4, 5, 6, and 7. It is possible that a significant difference between the groups may have arisen on one day out of six by chance. Secondly, studies on penicillin have raised the possibility of a greater risk of symptom relapse following antibiotic treatment.[4] This study did not address this question, but the possibility of greater long-term morbidity following antibiotic treatment remains. Thirdly, given the expense of cefixime, potential side-effects, and the danger of resistance with a broad spectrum of antibiotics, is it sensible to use such drugs to effect a small reduction in symptoms in what is essentially a self-limiting illness?

MICHAEL MOORE

Three Swans Surgery
South and Western Region Research
General practice
Salisbury

PAUL LITTLE

Aldermoor Health Centre
Aldermoor Close
Southampton

GREG WARNER

Nightingale Surgery
South and Western Region Research
General practice
Romsey

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Audit

Sir,

I am increasingly concerned by the description of original papers as 'audit' when, in fact, they are nothing of the sort. An example of this misrepresentation was the paper by Vernon *et al* (May *Journal*) on 'How general practitioners manage children with urinary tract infection: an audit in the former Northern Region'.[1] It is perhaps pertinent that the previous paper in this issue by Lough and Murray, 'Training for audit: lessons still to be learned',[2] clearly demonstrated that trainers are failing to recognize basic audit methodology. Perhaps this also applies to referees and editors? If, as the Government white papers of the last year suggest, clinical audit should be further integrated into the development of quality assurance in primary care, then there are urgent questions to ask regarding the training of all general practitioners and other members of the primary health care team in basic audit methodology. I would suggest that Medical Audit Advisory Groups and Primary Care Audit Groups must take some lead responsibility in addressing these problems.

I K CAMPBELL

The Heacham Group Practice
Snettisham Surgery
Common Road, Snettisham
Norfolk PE31 7PE

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Sir,

The paper by Lough and Murray[1] (May *Journal*) has made conclusions that are unjustified. In their discussion they mention that approximately 10% of projects were judged to be below the minimum competence level, and thus it must follow that nearly 90% of projects were satisfactory, which would seem to indicate that trainers spent a great deal of time and effort on individual registrars' summative assessment audit. Trainers have had an