working hours were classified according to their presenting complaint, route of referral, and previous attendance at the department. The information collected was tested against two null hypotheses suggested by Dr Watson's article, using the chi-squared technique.

In this small purposive sample no significant difference could be demonstrated with respect to inappropriate attendance either between old and new patients or between those who were self-referred and those arriving through other agencies. This contradicts the subjective impression of some casualty officers that patients may be using the accident and emergency department in lieu of their general practitioner. It also adds support, from a different locality and a different viewpoint, to the conclusion that even though total casualty department work load may be increasing, this does not reflect a shift away from the general practitioner to the hospital department.

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- ¹ Durbin, F C, *British Medical Journal*, 1974, **1**, 125.
² Morgan, W, *et al*, *Hospital and Health Services Review*, 1974, **70**, 189.

Fenclofenac-induced nephrotic syndrome?

SIR,—We feel that the recent report of fenclofenac-induced nephrotic syndrome by Dr D V Hamilton and others (*BMJ*, 11 August, p 391) should be interpreted with caution. We have recently seen a similar case of nephrotic syndrome in rheumatoid arthritis in which there was complete spontaneous recovery and no demonstrable cause.

The patient is a 60-year-old woman with a three-year history of severe seropositive rheumatoid arthritis who has marked rheumatoid deformities and nodules. In March 1979 she was noted to have proteinuria of 0.9 g/l. At this time she had been on penicillamine for six weeks and was having 250 mg twice daily, with naprosyn 750 mg daily and indomethacin suppositories at night. Drugs used in the past included a 15-month course of gold (stopped in August 1978), a three-month trial of fenclofenac in 1977, and intermittent ibuprofen. Penicillamine was stopped, but proteinuria increased and nine weeks later sacral and ankle oedema developed. She was admitted for investigations, which revealed a serum albumin of 12 g/l and urinary protein of 7.5 g/l. Other abnormalities included: urea 8.3 mmol/l, creatinine 138 μ mol/l, haemoglobin 10.6 g/dl, viscosity 2.22 mPa s (2.22 cP), rheumatoid arthritis haemagglutinating antibody titre 1/160, and plasma globulin 51 g/l (increased α_2 -globulins on electrophoresis). C3, C4, C_{H50}, and C-reactive protein were normal. There was no evidence of the hepatitis B surface antigen (HBsAg). A rectal biopsy did not show any evidence of amyloidosis or vasculitis. Intravenous urography was normal. Renal biopsy was performed and showed a mild, diffuse increase in mesangial cells and matrix with moderate diffuse focal interstitial fibrosis. The immunofluorescence test gave essentially negative results and there was no evidence of basement membrane deposits. During a period of three weeks, without any change in treatment, urinary protein decreased to 0.06 g/l and albumin increased to 33 g/l.

This patient clearly had an acute episode of severe nephrosis in rheumatoid arthritis which was entirely self limiting. Although the patient had been on penicillamine, neither the time course of the illness nor the renal histology were consistent with penicillamine nephropathy, the features of which have been recently documented.¹ No cause was demon-

strated in this case but the mesangial nephropathy would be consistent with an acute episode unrelated to her rheumatoid arthritis, such as a viral infection. Clearly there is the possibility of falsely implicating any drugs being taken, with the ubiquitous non-steroidal anti-inflammatory drugs most liable to guilt by association. A variety of renal abnormalities have been described in rheumatoid arthritis, and the role of anti-inflammatory drugs remains unclear.²

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- ¹ Bacon, P A, *et al*, *Quarterly Journal of Medicine*, 1976, **180**, 661.
² Symposium on Renal Disease in Connective Tissue Disorders, *European Journal of Rheumatology and Inflammation*, in press.

Psychosocial stress in pregnancy

SIR,—I read with interest the article by Dr Richard W Newton and others (18 August, p 411). Their conclusion that stressful events may precipitate premature labour is hardly justified by the data presented.

It is well known that women who have delivered premature babies may experience feelings of guilt and recrimination. It is likely that these mothers, when compared with mothers of normal babies, will have better recall of the major life events, especially the more subjective ones listed such as the husband being sarcastic, undue worry over having a handicapped child, and increase in family arguments.

There is a further problem in the method of interview described. Published work¹ has shown that different interviewers may obtain different responses to the same questionnaire. It is therefore unfortunate that the two groups of mothers were questioned by different interviewers.

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- ¹ Choi, I C, and Comstock, G W, *American Journal of Epidemiology*, 1975, **101**, 84.

Spread of steroid-containing foam after intrarectal administration

SIR,—There has recently been an extensive advertising campaign advancing new evidence on the spread of steroid foam for intrarectal use in the management of ulcerative colitis. The advertisers have taken the unpublished results of a study presented at the March 1979 meeting of the British Society of Gastroenterology and used them to demonstrate the efficacy of their preparation. This study has now been published in abstract form but not in detail.¹ [A paper will shortly be published in the journal.—Ed, *BMJ*.]

This would presumably be quite justified were it not for the fact that a similar study using a slightly different technique reported to the Surgical Research Society in January this year by my colleagues and myself showed markedly different results. This latter study has now been published both in abstract form² and in detail.³ The results of both studies are known to the advertisers yet they have publicised only the favourable one.

I completely accept that our study, presented to the Surgical Research Society, may

have used incorrect methods and thus produced fallacious results. It is equally the case, however, that the results presented to the British Society of Gastroenterology arise from incorrect technique. We consider that the method used for labelling the foam in this latter study fundamentally altered its characteristics and thus gave erroneous information. The answer will only come from further study of the characteristics of the labelled foam used in each investigation.

The fact remains that a company promoting a treatment for a serious condition has apparently ignored one of two sets of contradictory data. Advertising by pharmaceutical companies should present all the evidence to the medical practitioner in a scientific fashion in order that he can decide for himself the merits of the preparation which he is being encouraged to use.

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- ¹ Farthing, M J G, *et al*, *Gut*, 1979, **20**, 453.
² Hay, D J, *et al*, *British Journal of Surgery*, 1979, **66**, 359.
³ Hay, D J, *et al*, *British Medical Journal*, 1979, **1**, 1751.

* * * We sent a copy of this letter to the manufacturers, whose reply is printed below.—Ed, *BMJ*.

SIR,—Professor M Irving refers to a series of advertisements used by us in the promotion of Colifoam. These quoted extracts from a clinical paper presented at the British Society of Gastroenterology in March of this year and subsequently published in abstract form in *Gut*.

Professor Irving's main point is that comparable work undertaken by his own unit was not simultaneously included in our promotional material. However, the investigation by Professor Irving's unit was not published until May of this year, when it appeared in abstract form in the *British Journal of Surgery*; subsequently it was published in full in the *BMJ*.

Thus when our promotional material was prepared we had no knowledge that Professor Irving's work had been completed and therefore were not able to make any reference to it. Future promotional material for Colifoam will, of course, include references to both trials, in line with our normal practice. Since publication of the full work in the *BMJ* in June our representatives have been featuring this in their detail activity side by side with the other work. I hope this fully clarifies the sequence of events in a promotional exercise that might otherwise have implied an omission on our part.

V T KELLY

Stafford-Miller Limited,
Hatfield, Herts AL10 0NZ

Design of forms for clinical trials

SIR,—While Drs Patricia Wright and John Haybittle (1 September, p 529) are to be congratulated on their attempts to design simple forms for clinical trials, we are a little uneasy about their suggestion that in order to improve accuracy clinicians might be asked to record the physical size of tumours.

We have already shown that data recording may well be extremely unreliable when tumour size and lymph node status in breast cancer are considered.¹ More recently Irving