capable of producing both superoxide and hydrogen peroxide with the reintroduction of the blood supply.⁵ Dr Murrell 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 suppresses 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