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- Scandinavian Simvastatin Survival Group. Randomised trial of cholesterol lowering in 4444 patients with coronary heart disease: the Scandinavian simvastatin survival study (4S). *Lancet* 1994;344:1383-9.
- Long-term Intervention with Pravastatin in Ischaemic Heart Disease (LIPID) Study Group. Prevention of cardiovascular events and death with pravastatin in patients with coronary heart disease and a broad range of initial cholesterol levels. *New Engl J Med* 1998;339:1349-57.
- Sacks FM, Pfeffer MA, Moye LA. The effects of pravastatin on coronary events after myocardial infarction in patients with average cholesterol levels. The CARE study. *New Engl J Med* 1996;335:1001-9.
- Heart Protection Study Collaborative Group. MRC/BHF heart protection study of cholesterol lowering with simvastatin in 20,536 high risk individuals: a randomised placebo-controlled trial. *Lancet* 2002;360:7-22.
- Cannon C, Braunwald E, McCabe C, Rader D, Rouleau J, Belder R, et al. Comparison of intensive and moderate lipid lowering with statins after acute coronary syndromes. *New Engl J Med* 2004;350.
- Wald N, Law M. A strategy to reduce cardiovascular disease by more than 80%. *BMJ* 2003;326:1149-55.
- Haines A, Jones R. Implementing findings of research. *BMJ* 1994;308:1488-92.
- Million Women Study Collaborators. Breast cancer and hormone replacement therapy in the million women study. *Lancet* 2003;362:419-27.
- Hippisley-Cox J, Pringle M, Crown N, Coupland C. Dose hormone replacement therapy protect against ischaemic heart disease? Evidence from a general practice based case control study. *Br J Gen Pract* 2003;53:191-6.
- Lagro-Janssen A, Rosser W, van Weel C. Breast cancer and hormone replacement therapy: up to general practice to pick up the pieces. *Lancet* 2003;362:414-5.
- Anon. From research to practice. *Lancet* 1994;344:417-8.
- Jick H, Zornberg GL, Jick SS, Seshadri S, Drachman DA. Statins and the risk of dementia. *Lancet* 2000;356:1627-31.
- Jick H, Kaye J, Vasilakis-Scaramozza C, Jick S. Risk of venous thromboembolism among users of third generation oral contraceptives compared with users of oral contraceptives with levonorgestrel before and after 1995: cohort and case control analysis. *BMJ* 2000;321:1190-5.
- Hippisley-Cox J, Pringle M, Cater R, Wynn A, Hammersley V, Coupland C, et al. Electronic record in primary care—regression or progression? Cross-sectional survey. *BMJ* 2003;326:1439-43.
- McMahan AD. Approaches to combat with confounding by indication in observational studies of intended drug effects. *Pharmacoevidenciol Drug Saf* 2003;12:551-8.
- Barnett AH, Bain SC, Bouter P, Karlberg B, Madsbad S, Jervell J, et al. Angiotensin-receptor blockade versus converting-enzyme inhibition in type 2 diabetes and nephropathy. [See comment]. *New Engl J Med* 2004;351:1952-61.
- Hammersley V, Hippisley-Cox J, Wilson A, Pringle M. A comparison of research general practices and their patients with other practices—cross sectional survey in Trent. *Br J Gen Pract* 2002;52:463-8.
- Hippisley-Cox J, Hammersley V, Pringle M, Coupland C, Crown N, Wright L. How useful are general practice databases for research? Analysis of their accuracy and completeness in one research network. *Health Informatics J* 2004;10:91-109.
- Hippisley-Cox J, Coupland C. The effect of statins on mortality in patients with ischaemic heart disease: population based cohort study with nested case control analysis. *Heart* 2005 (in press).
- Rothman K, Greenland S. *Modern epidemiology*. 2nd ed. Boston: Lippincott-Raven, 1998.

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The bad news and the bad news

I recently saw a 64 year old man with a skin lesion on his knee that had been intermittently weeping pus over the past four weeks and had been growing in size. The lesion was well demarcated, granulomatous, and about 2x2 cm in size. He had had it for over a year, but it had never bothered him until recently. The lesion did not look infected, so I decided to remove it and send it for histology.

Four days later, I was called by a consultant pathologist, who started quizzing me about this patient. Specifically he wanted to know the patient's sexual orientation and whether he was an intravenous drug user. The patient was homosexual, and when I told the consultant so it seemed to confirm his suspicion. "This looks like a nodular Kaposi's sarcoma," he said, "but I will need to send it to an expert in London to confirm this as I am really not certain."

From what I knew about Kaposi's sarcoma, it was nearly always linked to HIV infection. I felt apprehensive about telling the patient of the diagnosis for several reasons: I still had no definite confirmation that this was Kaposi's sarcoma (the London expert would have the final word on that) and I would have to tell the patient he had a cancer and very possibly HIV infection as well. Talk about breaking bad news. I therefore decided not to tell the patient until I had the expert opinion.

I finally heard back from the consultant in London: "Yes this has all the features of Kaposi's sarcoma." I called the patient in and broke the bad news to him. I told him that there was a good chance that this form of cancer was linked with being HIV positive, and he understood this. He explained that he had always avoided the issue of HIV testing because he was frightened. He was understandably shaken.

In our surgery we put alerts on the patient's computer records and had a "critical event" meeting to

alert all staff about the "high risk patient." I talked to the regional genito-urinary medicine clinic, where the patient was seen then next day.

Then, a week later, I received some unexpected news from the clinic (the patient having given consent for the information to be sent to me): several HIV tests had been carried out, and all were negative. Everyone was most surprised. The patient had no Mediterranean or Jewish background and did not seem to be immunocompromised, so why had he developed the sarcoma? The patient telephoned me and was understandably over the moon. From thinking that he was HIV positive to having "just" a skin cancer made a huge difference to him.

This incident made me think of how rarely things are clear cut in medicine. All the surgery staff were convinced that this patient was infected with HIV, possibly even immunocompromised with AIDS. It turned out we were all wrong. As doctors, we rely on odds and likelihood, but it is important to bear in mind that sometimes the unlikely (odd) will happen and take us by surprise.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com> Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.