

I agree with them that the limitations of the erythrocyte sedimentation rate should be recognised but would take issue with critics who have suggested that its measurement should be abandoned because it is strongly influenced by anaemia, which cannot be corrected for and thus confuses the interpretation. The erythrocyte sedimentation rate is simple to estimate and is ideal for the busy doctor's surgery, for a district hospital's outpatient clinics, and at the bedside.

I would particularly emphasise the need for its immediate estimation in any patient around 60 who presents with intractable headache, particularly occipital and temporal; pain in the face, jaw, and mouth exacerbated by chewing; and tenderness over the scalp and temporal and cranial arteries.¹ I regard giant cell arteritis as one of the acute emergencies of general medical practice. A delay of even a few hours in starting steroid treatment may result in irreversible visual failure. Once diagnosed on clinical grounds steroid treatment must be started immediately and the patient must not be allowed to leave until the erythrocyte sedimentation rate is available. It is unacceptable to waste valuable time in sending blood off to a hospital laboratory with facilities for measuring plasma viscosity instead of estimating the erythrocyte sedimentation rate. If untreated some 30% of patients develop serious visual complications² owing to obliteration of the central artery to the retina or more commonly to ischaemic optic neuropathy as a result of the ciliary arteries supplying the optic nerve and disc being affected.³

An elderly patient presenting with sudden loss of vision in one or both eyes needs an intravenous injection of 10 mg dexamethasone before admission to hospital and before the result of the erythrocyte sedimentation rate is known.⁴ In patients with giant cell arteritis a daily oral dose of about 80 mg prednisolone should then be continued until the systemic manifestations of the disease have completely resolved and erythrocyte sedimentation rate has fallen significantly.⁵ With this high dose of steroids toxic effects may develop, but this is surely a small price to pay compared with permanent loss of vision. Once taking a low maintenance dose of steroids, patients should be warned that any exacerbation of symptoms, particularly deterioration of vision, demands that the dose should be immediately increased. Details of this procedure should be given to the family doctor as well to avoid possible delay.

As with other generalised inflammatory disorders, the efficacy of the erythrocyte sedimentation rate as a guide to dose reduction and prognosis is well established. This is certainly not the time to scrap it.

ANTHONY G FREEMAN

Swindon SN3 1QE

- 1 Stuart J, Lewis SN. Monitoring the acute phase response. *Br Med J* 1988;297:1143-4. (5 November.)
- 2 Freeman AG. Is the ESR outdated? *Lancet* 1982;ii:570.
- 3 Parsons-Smith G. Sudden blindness in polymyalgia arteritica. *Br Med J* 1977;ii:1536-7.
- 4 Jennings GH. "Temporal arteritis": some aspects of subacute arteritis in later life. *Br Med J* 1948;ii:443-7.
- 5 Crompton MR. The visual changes in temporal "giant cell arteritis." Report of a case with autopsy findings. *Brain* 1959;82:377-90.
- 6 Freeman AG, Ross Russell RW. Polymyalgia arteritica. *Br Med J* 1977;ii:1412.

Anaesthetic complications of a weight reducing regimen

SIR,—Dr J M Field's case report¹ raises the important issue of whether attempts should be made hastily to correct moderate chronic hypokalaemia before surgery.

Only 2% or about 60 mmol of the total body potassium is extracellular, and the time for equilibration between this and the intracellular com-

partment is as long as 40 hours.² In chronic depletion the total body deficit may approach 1000 mmol³ and rapid intravenous administration will be unable to correct this but it will acutely increase the ratio of extracellular to intracellular potassium and predispose to potentially dangerous arrhythmias.^{4,5} Furthermore, there is no evidence for an increased incidence of arrhythmias during anaesthesia in otherwise healthy patients with isolated moderate chronic hypokalaemia.⁶ Dr Field points out that the only prospective study showed no association between chronic hypokalaemia and arrhythmias during surgery.⁷ Studies that have reported arrhythmias in the presence of hypokalaemia have been confined mainly to patients with cardiac disease.^{8,9} Cardiac complications are also more frequent in the elderly and in patients undergoing intrathoracic, aortic, or major intraabdominal surgery.¹⁰

In a young patient about to undergo appendectomy with no history of cardiac disease the presumed benefits of increasing the serum potassium concentration do not warrant delaying emergency surgery and this manoeuvre may itself produce arrhythmias during anaesthesia, especially when suxamethonium is used for intubation, and further increase the extracellular to intracellular potassium ratio.

D S SELSBY

Department of Anaesthesia,
General Infirmary, Leeds LS1 3EX

- 1 Field JM. Anaesthetic complications of a weight reducing regimen. *Br Med J* 1988;297:1383. (26 November.)
- 2 Johnson JE, Hartsuck JM, Zollinger RM, Moore FD. Radio-potassium equilibrium in total body potassium: studies using "K and "K. *Metabolism* 1969;16:663-7.
- 3 Roizen MF. Anesthetic implications of concurrent diseases. In: Miller RD, ed. *Anesthesia*. New York: Churchill Livingstone, 1986:313.
- 4 Wong KC, Kawamura R, Hodges MR, Sullivan SP. Acute intravenous administration of potassium chloride to furosemide pretreated dogs. *Can Anaesth Soc J* 1977;24:203-11.
- 5 Surawicz B, Chlebus H, Mazzoleni A. Hemodynamic and electrocardiographic effects of hyperpotassemia. Differences in response to slow and rapid increases in concentration of plasma K. *Am Heart J* 1967;73:647-64.
- 6 McGovern B. Hypokalemia and cardiac arrhythmias. *Anesthesiology* 1985;63:127-9.
- 7 Vitez TS, Soper L, Wong KC, Soper PG. Chronic hypokalemia and intraoperative dysrhythmias. *Anesthesiology* 1985;63:130-3.
- 8 Nordrehaug JE, Lippe G Von Der. Hypokalaemia and ventricular fibrillation in acute myocardial infarction. *Br Heart J* 1983;50:525-9.
- 9 Martin D. Thiazide induced hypokalemia: association with acute myocardial infarction and ventricular fibrillation. *JAMA* 1978;239:43-5.
- 10 Goldman L, Caldera DL, Nussbaum SR, et al. Multifactorial index of cardiac risk in noncardiac surgical procedures. *N Engl J Med* 1977;297:845-50.

Chlamydia: One step forward or two backwards?

SIR,—Dr Penny Owen and others suggested a role for general practitioners in the management of chlamydial infection.¹ This leads us to consider the wider issue of who should treat sexually transmitted disease. Traditionally, specialists in genitourinary medicine (formerly known as venereologists) diagnosed and treated venereal infections and arranged for the sexual contacts to be traced. This worked well for gonorrhoea: a man who developed distressing symptoms after a sexual contact would refer himself to a special clinic for treatment, and his female contacts (who might be symptomless) could be traced. Chlamydial infection and the sexually transmitted viral infections often do not lend themselves to this approach, and the number of patients presenting directly to the clinic represent only a small fraction of the cases occurring in the community. Therefore many cases of these infections will be diagnosed (or overlooked) by other doctors, particularly general practitioners, family planning doctors, and gynaecologists. If doctors outside a

specialist clinic suspect a sexually transmitted disease should they attempt to treat it themselves or should they refer the patient to a genitourinary medicine clinic?

Genitourinary medicine clinics are staffed by people who are familiar with asking detailed questions about sexual matters and are experienced in performing genital examinations. They have easy access to a range of diagnostic tests (such as immediate microscopy) and have the assistance of specially trained contact tracers and established networks to facilitate contact management. These favourable conditions are unlikely to prevail outside a specialist clinic. A general practitioner can take a chlamydia swab, prescribe treatment, and advise that the sexual partner should seek medical attention, but the contact is unlikely to be a patient at the same practice. Confidentiality may be hard to maintain in a general practitioner's surgery, and the patient may well prefer the anonymity of a genitourinary medicine clinic. The patient may be embarrassed to consult the general practitioner, who may think it necessary to be judgmental in approach, which may damage a previously good doctor-patient relationship. Finally, diagnosis of one sexually transmitted disease implies the need to screen thoroughly for other infections.

Some patients will prefer the comparative familiarity of the general practitioner's surgery to the (imagined) stigma of attending a genitourinary medicine clinic. Ideally, general practitioners should be aware of all the health problems of their patients and know what treatment they are receiving. General practitioners are well placed to screen patients for infection—for example, sexually active women presenting with vaginal discharge—and in so doing could help to reduce the reservoir of undiagnosed infection in the community. This requires time and resources, however, which may be particularly scarce in busy inner city practices where sexually transmitted diseases may be most prevalent.

We hope for and welcome a greater role for general practitioners in this subject as awareness of the prevalence and importance of sexually transmitted diseases increases and diagnostic facilities become more widely available. Specialists should encourage this trend and communicate clearly the elements of good genitourinary practice. Currently few practices will have the necessary time, equipment, and skill to manage sexually transmitted disease adequately, and poor management could have serious consequences. Therefore, most general practitioners who suspect or diagnose sexual transmitted disease should continue to refer the patient to a genitourinary medicine clinic.

DAVID M COKER
DEREK J TIMMINS
COLM O'MAHONY

Department of Genitourinary Medicine,
Royal Liverpool Hospital,
Liverpool 7

- 1 Owen P, Munro J, West R. Chlamydia: one step forward or two backwards? *Br Med J* 1988;297:1267. (12 November.)

Diagnosing and treating dementia

SIR,—Minerva questions whether clinicians are overzealous in their investigation of patients with dementia,¹ quoting Clarfield's finding that, although at least 11% of such patients have a potentially reversible cause, complete resolution of functioning is seen only rarely in practice.² Minerva's conclusions are perhaps unduly pessimistic. One problem is the difficulty clinicians have in correctly diagnosing dementia. Dr Anne Homer and others (8 October, p 894) showed the discrepancy between findings at necropsy and