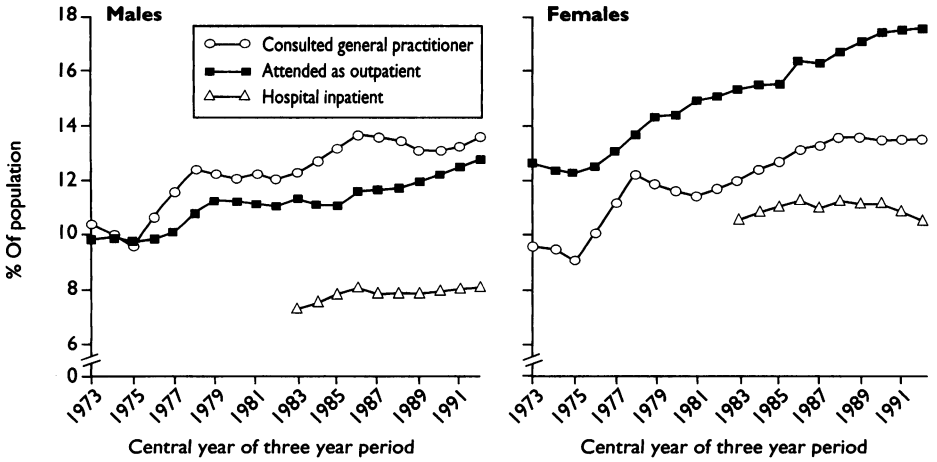

Trends in use of NHS services: percentages (three year moving averages) of patients who consulted their general practitioner in past 14 days, attended outpatient clinic or accident and emergency department in past three months, and had inpatient stay in past year

has not altered the rates from those obtained from raw figures.

The figure shows that the proportion of people consulting NHS general practitioners has risen since the mid-1970s—for female patients to a greater extent than for male patients; the proportion of people attending outpatient departments has increased over the same period, but the increase seems to have halted recently; and the proportion of people who were hospital inpatients over the period has changed little, apart from a slight increase in male patients.

During 1992 and 1993, 4% of people were treated as day patients. The general household survey provides other valuable data relevant to the health services, including data on self reported acute sickness, limiting chronic illness, contraceptive use, drinking, and smoking. More use should be made of this valuable source.

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Statistics would make Stalin proud

EDITOR,—The article by the Radical Statistics Health Group on indicators of success in the health service[1] leads us to ask what the NHS stands for today. The answer seems to be No Honest Statistics. The use of flawed statistics is another example of Stalinism in the NHS.[2] The government has radically transformed the NHS and knows that this has worked because it has the figures to prove it. Likewise, Stalin could prove the success of collective farming by his statistics on crop yield. The truth, however, was evident by the empty shelves in the shops.

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Polymyalgia rheumatica and giant cell arteritis

High dose corticosteroids are recommended

EDITOR,—We disagree with Gillian Pountain and Brian Hazleman's assertion that 20-40 mg of prednisolone is adequate initial treatment for patients with giant cell arteritis who have no ocular symptoms. As the authors state, appreciable visual loss occurs in 30-50% of patients with untreated giant cell arteritis. Anterior ischaemic optic neuropathy accounts for 90% of these cases, the remainder being secondary to retinal artery occlusions or, rarely, an ocular ischaemic syndrome. Although prodromal symptoms such as transient obscuration of vision or photopsia may herald ocular involvement, patients rarely present with these symptoms before the onset of profound visual loss. It is therefore extremely difficult to predict which patients with giant cell arteritis will go on to develop ocular complications, and all patients, even if they do not have visual symptoms, should be considered to be at risk of ocular involvement.

Two studies have advocated low dose steroid treatment in the management of giant cell arteritis. Delecoeuillerie *et al* retrospectively investigated the outcome in 78 cases and found that the 25 patients who were treated with 10-20 mg prednisolone/day had no greater ischaemic or ocular morbidity than the remaining 53 patients, who received initial treatment with 30-90 mg prednisolone/day.[2] Kyle and Hazleman reported that in their prospective series of 35 patients all but two were successfully treated with 40 mg prednisolone as an initial dose.[3] The studies, however, included too few patients receiving low dose treatment to be convincing, especially as the rate of visual complications in untreated cases is as low as 30%.

Ophthalmologists are aware of the potential risks of high dose steroid treatment in elderly patients[4] and of the disastrous visual consequences of inadequate steroid treatment in giant cell arteritis.[3] Until larger randomised controlled series show that lower doses really do prevent ischaemic complications we believe that an initial dose of 20-40 mg prednisolone/day is inadequate in all patients in whom the clinical history and results of examination strongly suggest giant cell arteritis (with or without confirmatory results of temporal artery biopsy). We recommend that these patients should receive an initial five to seven day course of 1 mg prednisolone/kg, which may then be rapidly tapered, depending on the erythrocyte sedimentation rate and symptoms. Many ophthalmologists now elect to admit patients with arteritic anterior ischaemic optic neuropathy to give a 1 g intravenous infusion of methylprednisolone followed by high dose oral treatment.

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Synovitis and polymyalgia rheumatica can coexist

EDITOR,—Gillian Pountain and Brian Hazleman state that persistent synovitis in polymyalgia rheumatica is uncommon and suggests an alternative diagnosis such as rheumatoid arthritis.[1] This is a common misconception. Studies have shown evidence of extensive synovitis in patients with polymyalgia rheumatica.[2-3] Evidence suggests that most elderly patients with a diagnosis of seronegative rheumatoid arthritis have a disease process similar to polymyalgia rheumatica except that the synovitis results in more affected joints being clinically detectable.[4] In these patients the symptoms, lack of erosive changes on radiography, response to treatment, and long term outcome suggest that polymyalgia rheumatica and seronegative rheumatoid arthritis are part of the same disease process or are identical.[4,5] This has important implications for treatment.

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Consider prophylaxis for steroid induced osteoporosis

EDITOR,—Gillian Pountain and Brian Hazleman consider that elderly women receiving long term corticosteroid treatment should be given disodium etidronate with calcium carbonate as the most effective prophylaxis to prevent osteoporosis.[1] This is of particular importance in patients with giant cell arteritis since it is a disease predominantly of older women and has serious risks if the steroid dose is not adequate. Unfortunately, there is no agreed safe dose, with some authors disputing the claim that low doses carry little risk. Furthermore, bone loss is greatest immediately after the menopause, so how effective prophylaxis for osteoporosis can be in those aged 60-75 is unknown. Finally, the study by Skingle and Crisp referenced in the article showed a significant increase in the bone mineral density of only the L1-L4 vertebrae and not in the neck of femur, which may be a more important clinical site; the vital data—namely, the clinical end point of fractures associated with steroids—are not available.

Our attention has been drawn to recent articles advocating oestrogen replacement therapy for postmenopausal patients receiving long term