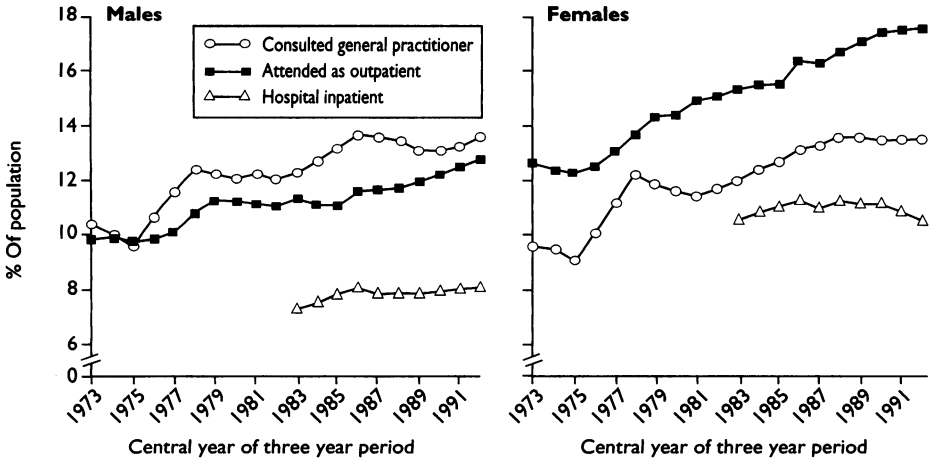

Trends in use of NHS services: percentages (three year moving averages) of patients who consulted their general practitioner in past 14 days, attended outpatient clinic or accident and emergency department in past three months, and had inpatient stay in past year

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

corticosteroid treatment.[2,3] Unfortunately, limited data to support this practice have been published. One study, however, showed no significant changes in lumbar spine density in women taking oestrogen and prednisolone compared with those taking oestrogen replacement without corticosteroids,[4] and another showed hormone replacement therapy to be effective in preserving bone mass in postmenopausal women with rheumatoid arthritis taking low dose corticosteroids.[5] We suggest that, while more information is awaited, the likely benefit of this form of prophylaxis should be considered in these patients.

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Authors' reply

EDITOR,—There is universal agreement that giant cell arteritis should be treated with systemic corticosteroids, but controversy remains about the optimum dose and duration of treatment. Most clinicians have strong views on the dose required, but some are based on tradition and anecdote. Most studies have used 40-60 mg prednisolone a day unless visual symptoms develop.[1] Some ophthalmologists have recommended beginning treatment with at least 80 mg prednisolone daily.[2] Intravenous steroids are occasionally used if visual complications occur. Patients should be advised that while they are taking a maintenance dose of steroids any exacerbation of symptoms, particularly sudden visual deterioration, requires an immediate increase in the dose.

Arthralgia and even synovitis, particularly of the knees, wrists, and sternoclavicular joints, can occur in polymyalgia rheumatica. Examination of synovial fluid, arthroscopic synovial biopsy specimens, and isotope scans have shown joint inflammation. In a prospective study, however, Kyle *et al* concluded that peripheral and axial synovitis was uncommon.[3] They attributed the discrepancies in the frequency of synovitis reported in studies to differing diagnostic criteria, the definition of synovitis, and the difficulty in interpreting scans and radiological pictures when there is coexisting degenerative disease.

Florid synovitis is uncommon in polymyalgia rheumatica. If this is persistent, the titre of rheumatoid factor is high, and there is a partial response to low dose corticosteroid then this suggests an alternative diagnosis of rheumatoid arthritis. Rheumatoid arthritis may have an onset suggestive of polymyalgia, particularly in elderly people.

We fully agree that our study, as well as other studies of cyclical etidronate, show a convincing effect on only the bone density of the lumbar spine and not on femoral density. However, glucocorticosteroids seem to have more effect on the spine than on the femur, and we therefore consider cyclical etidronate to be an entirely reasonable, safe, and effective treatment for patients taking prednisolone.

Hormone replacement therapy is also effective for bone loss induced by steroids, although there are relatively few data to support this. It is likely to have an effect on both spine and femoral bone mass. Unfortunately, it is often poorly tolerated by older women, and this is its major disadvantage in clinical use. Lastly, we agree with Stuart Jamieson and Fiona Thomson that further data on fractures are crucial, but we know of no studies of etidronate or hormone replacement therapy in steroid induced osteoporosis that give this information.

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Accrediting hospitals

EDITOR,—We agree with Ray Robinson that neglecting to audit outcomes of care is a fundamental flaw in the current systems of hospital accreditation in the United Kingdom.[1] Unfortunately, the accreditation system that is most widely used to certify hospitals and other institutions in the United States has the same shortcomings. The agency responsible, the Joint Commission on Accreditation of Healthcare Organizations, has made a bold and controversial decision to make reports of hospital performance publicly available. However, it is only just starting the move towards performance measures that are more heavily based on outcome.

There is an important lesson to learn from the United States, where purchasers, like those in the United Kingdom described by Charles D Shaw and Charles D Collins,[2] are dissatisfied with the information that accreditation gives them. As a result, hospitals and the health plans with which they are affiliated are receiving requests for different datasets from multiple purchasers who want to show that they are getting good value for their health care dollars.

Some forward thinking hospitals have independently started producing report cards. Examples of outcome measures used include risk adjusted morbidity, mortality, length of stay, readmission rates, surgical infection rates, and patients' satisfaction. Although these report cards are established as marketing tools, they have limited value for purchasers as methodologies and techniques of adjusting for risk vary, making it nearly impossible to compare hospitals in the same market area. As a result, some purchasers and providers are collaborating to agree on standard consumer satisfaction surveys and disease specific, patient focused outcome measures.

If purchasers in the United Kingdom are going to be in a position to compare providers on the basis of value, accrediting agencies should look across the Atlantic—not for examples of how to do it but rather to gain from the experience and mistakes in the United States and move ahead to the next stage of accountability with regard to quality, which must be based on outcome measures that are relevant to the consumer.

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General practitioners' separate out of hours contract

Accident departments cannot guarantee cover if GPs opt out

EDITOR,—As a former general practitioner, I was interested by general practitioners' call for a separate out of hours contract.[1] Consultant leaders Mr James Johnson and Dr Peter Hawker have pledged "unequivocal" support,[2] but it could be argued that general practitioners have a moral and legal responsibility to ensure that suitable alternative cover is arranged.

As an accident and emergency consultant for 17½ years, I am aware of the huge demands already placed on such departments out of hours. Can the ambulance service and receptionists, nurses, porters, radiographers, and pharmacists tolerate any more work? Dr John Gosnold suggests that funds should be switched from primary care to pay for more casualty officers,[2] but many accident and emergency departments cannot recruit enough staff already. The whole requirement for alternative cover cannot easily be met by a doctor deputising service, emergency nurse practitioners, or even general practitioners helping out in hospitals.

I have sat as a consultant representative on my local medical committee for over 10 years and have every sympathy with my colleagues in general practice. Before general practitioners opt out, however, alternative arrangements need to be set up quickly. The funding should be from the general practitioners themselves. Alternatively, my consultant colleagues may opt out of helping out.

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Fundamental review of primary and secondary emergency services is required

EDITOR,—The recent decision by general practitioners not to accept the government's current offer for out of hours responsibilities[1] should be seen as an opportunity to rationalise this aspect of the NHS. The changing role of general practice and the concept of being proactive, which entails health promotion, illness prevention, and purchase of secondary health care, present general practitioners with enormous problems if they are also to provide 24 hour emergency cover for the populations they serve.

The emergency services in both primary and secondary care could perhaps be integrated into a cohesive system of responding to health care emergencies. Although many schemes are organised to improve the service and reduce the load on individual general practitioners, there has been no formal attempt to capitalise on the skills of appropriately trained nursing and paramedical staff or to coordinate primary care emergency services with local accident and emergency departments.

It would not take great imagination to conceive a service that used the communication capacity of the ambulance service and its highly trained paramedical staff in linkage with appropriately trained medical staff who have an enthusiasm for emergency care. This should produce an effective and efficient emergency service that does not demoralise the staff involved.

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