Letters

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Diagnosis and management of polymyalgia rheumatica

Helliwell *et al* wrote an excellent article on the diagnosis and management of polymyalgia rheumatica, but I do question one of their statements that the average full-time GP would see five new cases of polymyalgia rheumatica (PMR) per year.[1]

They quote an incidence in the UK of 8.42 per 10 000 person years. In an average size practice of less than 2000 patients per GP, surely this correlates to a full-time GP seeing just one case of PMR per year?

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Authors' response

Thank you to everyone who has expressed interest in the clinical intelligence article on polymyalgia rheumatica (PMR). PMR is largely managed in the community. It has been shown that management varies widely[1] and diagnostic criteria are rarely used.[2] We hope that by summarising the recent British Society for Rheumatology (BSR) and British Health Professionals in Rheumatology (BHPR) guidance[3] we can help to improve outcomes for patients with PMR being managed in general practice.

We apologise for any confusion caused with the consultation estimates presented in the paper. Evidence from electronic consultation databases suggests that the 'average' general practice will have 20 patients per year consulting with PMR.[4] This will be a mix of newly diagnosed patients, in addition to prevalent cases. The *Musculoskeletal Matters* bulletin assumes an average practice size of 10 000 patients with four full-time doctors, which we acknowledge may not reflect the true 'average' sized practice. In this scenario GPs will see around five patients with PMR per year. The true consultation frequency may also vary for other reasons. In the UK, the age adjusted incidence rate is estimated to be around 8.4 per 10 000 patient years.[5] There are marked geographical differences found in the incidence of PMR. Incidence also varies greatly with age and sex and as such exact numbers of new patients seen will vary depending on the demographic make-up of the practice (for example, incidence rises from 0.65 per 10 000 patient years for females aged 40–49 years, to 26.9 per 10 000 patient years for females aged 70–79 years).

Optimising the diagnosis and management of PMR is hindered by the lack of primary care-based evidence. If *BJGP* readers are interested in participating in PMR research please get in touch using the contact details given below.

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5. Smeeth L, Cook C, Hall AJ. Incidence of diagnosed polymyalgia rheumatica and temporal arteritis in the United Kingdom, 1990–2001. *Ann Rheum Dis* 2006; **65(8):** 1093–1098.

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Telling the truth: why disclosure matters in chronic kidney disease

Your editorial in the April *BJGP* is very thought provoking but unfortunately misses the mark.[1] Primary care workers are considerably more sophisticated and well trained in the art of evidence than they were in 1960s. It was at this time that mild hypertension and its risks began to surface. In some ways hypertension and chronic kidney disease (CKD) are similar. Neither makes people feel sick and both are risk factors for heart disease and organ failure. In the 1960s the treatment of hypertension was unsophisticated with no good understanding of what impact we might have been having. It feels the same with CKD now.

Hypertension has since grown an evidence base that shows treatment has an impact on outcome. It has still been badly managed and guidance has been poor too; many practitioners have railed against old guidelines that took no notice of the patients blood pressure readings in the real world or did nothing to look at other factors. I remember too being shocked when I discovered the number needed to treat (NNT) for a middle-aged male with hypertension to prevent a stroke was 850. A move towards multiple measurements of blood pressure and looking at risk overall are steps in the right direction at trying to ensure we advise/treat those most at risk.