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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 widely¹ 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) guidance³ 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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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.

Now lets look at CKD.

Detection is unsophisticated and currently inadequate; the guidance that 3 months is enough is not good enough and draws parallels with hypertension detection.

Current evidence on intervention and effectiveness seems very light. I have asked everyone (including this journal) to provide me with a NNT for a patient with CKD III who need detecting and intervening with to prevent either a cardiovascular event or end-stage renal failure and nobody has so far managed. Could I ask you?

'So doctor, you want me to take more pills (or stop the only pills that give me a pain-free night's sleep). What is the benefit to me if you do this? ... And don't give me that politician speak ... give it to me straight.'

I fully understand the seriousness of chronic kidney disease and the cost and implications on patients. I am happy to share the truth with my patients but you need to find it and tell me it too.

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Calling time on the 10-minute consultation [letter]

Irving and Holden are encouraged by an electronic 'consultation length survey' where trainees 'largely recognise that longer consultations are needed in general practice'.¹

While this seems an excellent aim, may not be the table results — showing trainer consultation length and trainee preference, with the latter preferring longer consultations to those the former actually do — simply indicate we get slicker with experience?

Is there any plan to do a similar survey of the same trainees in the future, when more of the job is second nature?

That would be more likely to support the case being made, if it were to show the same result.

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Impact of health system reforms on primary care research

We have encountered barriers to health research caused by health system reforms. The PROMISE research programme on child and adolescent obesity was awarded £2.1 million in 2009 by the Department of Health's National Institute for Health Research. In one of the PROMISE projects, the Healthy Eating and Lifestyle Programme (HELP), a randomised controlled trial of a lifestyle intervention incorporating motivational and solution-focused techniques for 12-19 year-olds with obesity,¹ we have faced significant difficulties with recruitment. While recruitment to obesity studies in adolescents is known to be challenging,^{2,3} we have encountered obstacles that we believe arise from changes in the NHS.

First, GPs have frequently been reluctant to help with recruitment into the study because of uncertainty over what kind of obesity services clinical commissioning groups may provide in the future. There has also been a reluctance to help because some participants would not get the HELP intervention because of randomisation. Indeed, in some regions where no obesity services exist, GPs have expressed a preference to provide nothing for all, rather than something for some, despite the context of useful research. We think that unwillingness to engage may represent concerns about future services, rather than reflect a limited understanding of the principles of research.

Second, the dissolution of primary care trust (PCT) structures during our recruitment phase meant that many PCTs refused or were unable to assist with recruitment, and pathways to obtaining local research permissions were often opaque due to local reorganisation.

Similar problems have been encountered

in two other PROMISE studies. In our evaluation of the National Child Measurement Programme, participation by PCTs has been limited by future uncertainties. In another PROMISE study — developing and piloting an online tool for the assessment of overweight children in primary care — GPs have been reluctant to participate because of uncertainty surrounding future provision of services, as well as concerns about payments.

Obesity in childhood and adolescence is a key public health issue, yet little is known about how to treat it effectively. The Foresight report predicted that by 2050, 60% of males and 50% of females will be obese, costing the public around £50 billion per year.⁴ Obesity research for children and young people is important but now faces challenges from health system reforms. We would be interested to hear of similar experiences in obesity or other primary care research.

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On behalf of the HELP Trial Management Group.

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