LETTERS TO THE EDITOR

Management of leg ulcers
EDITOR—I congratulate Sarkar and Ballantyne for their excellent review on the management of leg ulcers. Additional comments regarding investigative methods of peripheral arterial pathology and the management of venous leg ulcers are, however, necessary.

In the United States, more than 1200 amputations are performed each week for a diabetic foot ulcer. One of the main causes of non-healing ulcer in diabetes is peripheral arteriopathy, which is often underestimated. In these patients, the ankle/brachial pressure index (ABI) is not sensitive enough. Falsely raised values are frequent in the case of incompressible arteries (medialcalcinosis), especially in diabetics, but they are also found in elderly patients or those with chronic renal failure. An ABI in the normal range is also observed in hypertensive or diabetic subcutaneous microangiopathy. Therefore, an arterial duplex ultrasound is recommended as well as recording the toe blood pressure or the skin perfusion pressure by plethysmography or laser Doppler.

Almost all venous leg ulcers can heal with adequate compression therapy. However, 30% to 40% of patients with venous leg ulcers have an isolated superficial venous incompetence (with the latter treated by surgery alone, avoiding long term use of compression bandages and reducing recurrence rate.2) Some degree of superficial reflux in the ulcer area is also found in patients with deep venous incompetence. Treatment of these local haemodynamic abnormalities may be an important factor in the healing of the ulcers and in prevention of their recurrence. Consequently, venous surgery is a good alternative for many patients, especially the elderly who have difficulties putting on compression stockings and those with peripheral arteriopathy, which may be aggravated by it. Phlebectomy of saphenous veins and their branches with ligation of incompetent perforating veins can be done under local anaesthetic and are therefore particularly suitable for elderly patients. Preoperative duplex ultrasound is, however, necessary to localise precisely the incompetent venous segments.

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Dr Findlay responds: I was very interested to read of the case presented by Sinha et al of a patient who had been treated with amiodarone and who developed hyperthyroidism several months after stopping the drug. Before the development of the hyperthyroid state the thyroid function was normal on four occasions while he was on amiodarone for nine months but there is a possibility, as can be seen in this case, that his original presentation was with refractory AF and subbiochemical thyroid disease. The most likely explanation, however, is that this is amiodarone induced hyperthyroidism as this has been reported to occur up to several months after stopping amiodarone treatment.1

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Giant cell (temporal) arteritis and temporal artery biopsy
EDITOR—I have read with interest the article by Dr Karseras, entitled “Ophthalmology and general medicine”.1 The author states that the representation of constitutional malaise, tenderness of temporal arteries, raised erythrocyte sedimentation rate (ESR) and rarely, biopsy will usually exclude this potentially blinding and lethal condition. I would like to emphasise some salient points particularly regarding the ESR and biopsy. A more specific and accepted description of the disease is “giant cell (temporal) arteritis” to distinguish it from Takayasu’s arteritis. It is important to maintain a high index of suspicion of the disease when seeing patients aged 50 years or older. The condition is an ophthalmic emergency. The condition can cause permanent total blindness unless urgent treatment with corticosteroids is provided. Treatment should not be delayed while awaiting results of the ESR or biopsy. Blindness can result from ischaemic optic neuropathy or retinal artery occlusion.2 Death from myocardial infarction or stroke can occur. The ESR is raised in about 90% of cases.3 Hence a normal ESR does not exclude the disease.

Most authorities recommend that temporal artery biopsy should be performed in all cases regardless of the presence of a firm clinical diagnosis and raised ESR. Treatment involves the long term use of oral prednisolone. The establishment of a biopsy proved diagnosis can be helpful particularly in cases where significant side effects from prednisolone occur. The biopsy should be ipsilateral to the side of the visual symptoms or headache. Contralateral biopsy can be considered in cases where the histology of the ipsilateral biopsy is negative. The biopsy should preferably be performed within one week of the start of steroid treatment.

The biopsy is positive in about 70% of cases of giant cell (temporal) arteritis.

Skin lesions may be present along the course of large and medium sized arteries. In addition, vasculitis may affect the ophthalmic artery but not necessarily the temporal artery. Hence negative histology does not necessarily exclude the diagnosis.

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Dr Findlay responds: I thank David Infeld for his interest in my article. There is not much in his letter of commentary that I would disagree with. Certainly where there is a high index of suspicion and symptoms fit the clinical picture I would personally start treatment on systemic steroids before the results of the ESR or biopsy. I am not too sure about undertaking a temporal artery biopsy in all cases, regardless of the presence of firm clinical diagnosis. Possible side effects from prednisolone do not seem to

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Foreign bodies in the nasal cavities

EDITOR—We read with great interest the review of foreign bodies in the nasal cavities compiled by Kalan and Tariq in a recent issue.1 The authors state that there are no comprehensive discussions on the subject of foreign bodies in the nose, but appear to have overlooked previous reviews by Worman and Baker,2 perhaps because their methodology lacks a systematic approach. Furthermore, we feel that the article affords undue emphasis to the role of the ear, nose, and throat (ENT) surgeon, and the requirement for their early involvement in this condition.

Emergency physicians frequently encounter foreign bodies in the nose, often in children brought to the hospital by their parents soon after insertion. In this group the presentation is not an offensive unilateral nasal discharge, as stated by Kalan and Tariq, but a history of recent insertion with local irritation. We have published a systematic review of foreign bodies in the nose and ear, including techniques for their removal in the emergency department.3 Current evidence indicates that the vast majority can be removed without complications by suitably trained emergency department staff, and without the need for ENT involvement. Locally we have been able to demonstrate considerable success with an appropriate teaching programme and a specific set of instruments for foreign body extraction.4

It seems likely that Kalan and Tariq’s article is biased by the fact that only difficult, complex, or late-presenting cases tend to be referred to an ENT surgeon. We wish to emphasise the important role that emergency physicians have in this common condition.


BOOK RECEIVED

The receipt of these books is acknowledged and this listing must be regarded as sufficient return for the courtesy of the sender. Books that appear to be of particular interest will be reviewed, space permitting. The journal does not publish unsolicited reviews.


BOOK REVIEWS

The reviewers have been asked to rate these books in terms of four items: readability, how up to date they are, accuracy and reliability, and value for money, using simple four point scales. From their opinions we have derived an overall “star” rating: * = poor, ** = reasonable, *** = good, **** = excellent.


This text is one of a series of books supported by “Treat Focus for the Promotion of Research and Development in Primary Health Care”. Its objectives are to provide the beginner in primary care research with an overview of appropriate methodology and an awareness of when and how to obtain specialist advice.

It is a delightful book to read as the text is laid out with clearly labelled, short, succinct, and highly relevant sections. It contains chapters on an introduction to research methodology, experimental designs, qualitative research, surveys and questionnaires, the use of interviews in a research project, and data collection by observation as well as a glossary and index. As there are five contributors, there is inevitably a degree of duplication. However, good cross referencing compensates.

Basic research terminology is defined and important information on topics such as sampling, calculation of sample size required, confidence intervals, and types of questionnaires is clearly set out in language which uses the minimum of jargon. Boxes and bullet points emphasise important facts and the text is interspersed with exercises which maintain reader’s interest and give feedback on standing. The chapters conclude with a summary, answers to the exercises and references, further reading, and sometimes suggestions for other resource information.

At £15.95, this book is certainly good value for money and should find a place on the bookshelves of aspiring primary care researchers.

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A candidate will ask “What does the examination test?” The answer is anything relevant to British general practice, a large and complex area which frequently changes. This book assists by presenting current information about issues relevant to general practice, including vocational training, medico-political issues in relation to primary care, practice management, audit, and revalidation. There is some repetition of certain topics resulting from the fact that a number of contributors are discussing current issues, however this did not detract from the value of the book.

The structure of the MRCGP examination changes almost as frequently as the medico-political scene and therefore the detailed explanation of the elements of the college exam is invaluable. The insights into what examiners are looking for together with some marking schedules are extremely useful. The book is concise and contains invaluable references to all the current papers with which candidates should be familiar. I can thoroughly recommend it, not only to candidates working towards their membership examination, but also GP trainers and GP principals alike.

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DIARY

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For more information contact: quality@bma.org.uk or fax +44 (0) 7383 6869.
Amiodarone induced hyperthyroidism

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