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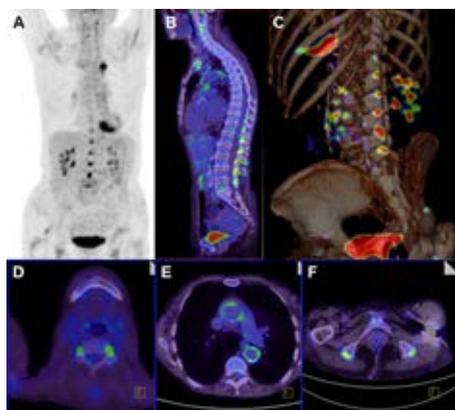
POLYMYALGIA RHEUMATICA

“One stop shop” diagnosis of polymyalgia rheumatica

Mackie and Mallen highlight that the diagnosis of polymyalgia rheumatica can be challenging and dependent on clinical experience and expertise, underscoring the need for better diagnostic algorithms.¹ Given the various differential diagnoses, including occult infection, cancer, and myositis, patients are often subjected to an array of investigations before the diagnosis is established (often by exclusion), resulting in delayed diagnosis and costs associated with misdirected investigations.

Fluorodeoxyglucose positron emission tomography/computed tomography (FDG PET/CT) enables whole body imaging of glycolytic metabolism and is widely used for cancer imaging.² Acute and chronic inflammatory processes also use glycolytic metabolism, making this technique extremely useful for imaging inflammatory diseases. It essentially enables “imaging of erythrocyte sedimentation rate” defining the location, pattern, and degree of inflammation.

Scans in polymyalgia rheumatica have a characteristic appearance (figure), with visualisation of distinctive interspinous



Fluorodeoxyglucose positron emission tomography/computed tomography (FDG PET/CT) in a patient with unsuspected polymyalgia rheumatica. (A) Maximum intensity projection image providing a whole body overview. (B, C) Coronal and three dimensional bone PET/CT scans showing interspinous bursitis correlating with back pain and stiffness. (D, E) Vasculitis of large and medium sized vessels, with high uptake in the aortic arch and major branches (vertebral arteries shown). (F) Widespread bursitis and enthesopathy

bursitis, widespread enthesopathy, synovitis, and background vasculitis of large or medium large vessels.^{3,4} PET/CT has specific patterns for the differential diagnoses including infection, cancer, and myositis, thereby providing a “one stop shop” for diagnosis.

Although FDG PET/CT is perceived as expensive, use of an accurate and high yield test upfront can pinpoint the appropriate investigations to be performed. This can prove more cost effective than performing an array of non-specific tests, which can lead to incorrect diagnosis and misdirected patient management. PET also provides more accurate and earlier assessment of response because glycolytic activity dissipates rapidly with effective treatment. The time has come for rheumatologists to embrace this technology to improve patient outcomes.

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Competing interests: None declared.

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IDIOPATHIC PULMONARY FIBROSIS

Benefit of lung transplantation

Dempsey and Miller drew attention to the inadequacy of medical treatments for idiopathic pulmonary fibrosis (IPF) and the optimism provided by the emergence of pirfenidone.¹ However, only a cursory note was given to lung transplantation, which seems to have been dismissed by the authors, who describe patients as “too frail or old” with “serious comorbidity.” We are worried that this viewpoint will foster a passive attitude to this successful treatment.

International Society for Heart and Lung Transplantation registry data from 2012 show that 37% of North American and 31% of worldwide lung transplants were performed for

IPF, compared with only 13% in Europe. This discrepancy is hard to explain. However, the proportion of patients with IPF given transplants in the US increased after the introduction of the lung allocation scoring system,² which prioritises patients on the basis of treatment benefit.

Although IPF has been associated with higher perioperative mortality than other conditions, this is probably because of delayed referral—long term outcomes have been shown to be excellent.³ In Ireland, five year survival in these patients is 79% after transplantation. Outcomes are similar in all age groups, including those over 65.^{4,5}

Lung transplantation is the only intervention with a proved survival benefit in this disease. Although future drug development should be viewed optimistically, treatments that are known to enhance survival should be focused on. Increased referrals to transplant centres, allied to improved organ utilisation for these patients, should be measured as key performance indicators. Advocacy aimed at achieving transplant rates of 30%, akin to the US, would provide considerable benefits.

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Competing interests: None declared.

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CLINICAL GUIDELINES

Time for SIGN to be transparent

Lenzer's article "Why we can't trust clinical guidelines" has attracted a considerable number of responses,¹ many of which highlight individual clinical guidelines where problems with conflicts of interest have arisen.

One option would be for clinical guidelines to have all potential conflicts of interest recorded and readily available to the reader. This would allow readers to make their own assessment of the advice given. Indeed, the Scottish Intercollegiate Guidelines Network (SIGN) states that "SIGN is committed to open declaration of competing interests in all its activities."² However, SIGN's programme lead stated on the 20 November 2013 in a personal communication to one of us (PJG): "It is my expectation that none of the guidelines prior to and including SIGN 114 (excluding SIGN 88, SIGN 93 and SIGN 101, which have been updated in the last three years) will have a record of the declarations of interest of the group members. This totals forty-four guidelines, of which six will have updates published in 2014 (with current declarations of interest)".

We urge SIGN and other guideline authors in a similar position to make it clear that current standards on transparency have not been met for many clinical guidelines still in use.

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Competing interests: None declared.

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- 2 Scottish Intercollegiate Guidelines Network. SIGN guidelines. Policy on declaration of interests. 2013. www.sign.ac.uk/pdf/doi-policy.pdf.

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SIGN's reply

We thank Gordon and Gordon for drawing our attention to the matter of declaration of competing interests in clinical guidelines, which we have discussed previously with Peter J Gordon.

We accept that some of our legacy guidelines were produced under governance arrangements that were different from the current process. All interests, however, were declared and managed during development and were available on publication of all of the extant guidelines to which Gordon and Gordon refer and for three years thereafter.

Under our current process, a register of interests for the guideline development group members can be viewed online at the SIGN website.

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TRANSPARENCY IN NHS COMMISSIONING

Serco Health's reply

Serco Health is properly resourced to deliver a safe high quality service in Suffolk.¹ A Care Quality Commission inspection in May found us compliant with all essential standards, including staffing.

Our standards of care are excellent, this shows in our friends and family test results—more than 90% of patients and carers are willing to recommend our services.

Serco has been commissioned to transform community health services in Suffolk on behalf of the NHS—we know that this will take time and effort from all parties.

The previous organisation that ran the service had 72 key performance indicators, but Serco has 188. In line with the objective of transforming the service, we agreed to report on several new indicators from April this year, which reflects how we and the commissioners want the service delivered. Of the 15 indicators that fall into this group, Serco is meeting seven. Five need input from other parts of the health system, and plans for the three that are fully under our control are on track.

It is true that we have received a contract query from commissioners. We have worked with them and have agreed remedial action plans that are on track to be delivered.

We are already delivering some excellent results, such as:

- Average length of stay in our community hospitals has dropped from 29.1 days to 22.6 days over the past six months; this benefits patients and means that we can support other partners in the health system by looking after more patients
- Our care coordination centre in Ipswich is open 24/7 providing a single point of access for referrers (this was not the case before we took over).

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Competing interests: Serco is one of the organisations about which allegations are made in the article.

- 1 Deith J. A healthy market? Lack of transparency raises doubts about NHS commissioning. *BMJ* 2013;347:f7115. (4 December.)

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RELEASE OF CLINICAL STUDY DOCUMENTS

Sign a petition to stop AbbVie's legal action against EMA

In 2010, the Nordic Cochrane Centre got access to clinical study reports and trial protocols at the European Medicines Agency (EMA) after filing a complaint to the European ombudsman, who concluded that these

documents do not contain commercially confidential information.^{1 2}

Since December 2010, the EMA has released more than 1.5 million pages on clinical information about medicinal products. However, in the spring of 2013, two US drug companies, AbbVie and InterMune, challenged the EMA's new openness policy at the European court. In its interim ruling, the court suspended the EMA from granting a third party access to clinical study reports on Humira (adalimumab) for Crohn's disease and access to certain documents on Esbriet (pirfenidone)—used for idiopathic pulmonary fibrosis.

The EMA challenged the interim suspension, and in December the European Court of Justice annulled the earlier interim orders and referred the matter back to the EU's general court for further consideration.³ Meanwhile, the EMA continues its policy of responding to outside requests for documents about clinical trials on other drugs.

AbbVie was until recently Abbott Laboratories. Humira—a monoclonal antibody that is the world's top selling drug³—can do serious, even life threatening, harm. At a meeting in Brussels in August, AbbVie made it clear that it nonetheless regarded clinical trial data on adverse events as confidential information that it was entitled to keep to itself. This elicited strong reactions from European drug regulators (<http://davidhealy.org/trade-wars-abbvie-v-china/>; AbbVie's statements come after 23 minutes).

This is a fight for right against wrong. Clinical trials data belong to all of us, and it is well documented that non-disclosure of trial data kills people in huge numbers.⁴ The major drug industry associations in Europe and the US support the two court cases. I therefore urge everyone who prioritises patient survival over commercial interests to sign a petition (<http://chn.ge/13clTyf>) calling on AbbVie and InterMune to drop their legal actions against the EMA. I also encourage doctors to boycott products from Abbott, AbbVie, and InterMune until they drop their legal actions.

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Competing interests: None declared.

Full response at: www.bmj.com/content/347/bmj.f4728/rr/671045.

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