The ESR returned to below 20 mm/h on at least one occasion in all except 3 of the 101 cases in which a follow-up result was available. The elevation of the ESR was only modest in these 3 cases (32, 28, 24 mm/h) and could be explained by continuing activity of the disease (2 cases) and a long-standing benign monoclonal gammopathy. The lowest recorded ESR was below 15 mm/h in 95% of the 101 cases and 10 mm/h or less in 76% of the patients. However, like Ellis and Ralston we observed several patients who were successfully managed on their symptoms alone and do not advocate that the dose of prednisone should be adjusted with the sole aim of keeping the ESR at a normal level. This may not prevent complications. One patient developed permanent loss of vision in one eye 2 months after the institution of corticosteroids, when she was completely symptom-free with an ESR of 3 mm/h. However, we feel that the ESR remains a most useful investigation in the diagnosis of PMR/GCA and recommend that, if a normal result is obtained initially, the ESR should be repeated at short intervals, as it may well be elevated subsequently. We should also recommend that the CRP should be measured in the suspected case with a normal ESR.

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References

- 1 Ellis ME, Ralston S. The ESR in the diagnosis and management of the polymyalgia rheumatica/giant cell arteritis syndrome. *Ann Rheum Dis* 1983; **42**: 168-70.
- 2 Huston K A, Hunder G G, Lie J T, Kennedy R H, Elveback L R. Temporal arteritis. A 25 year epidemiological, clinical and pathologic study. *Ann Intern Med* 1978; **88**: 162-7.
- 3 Hamilton C R, Shelley W M, Tumulty P A. Giant cell arteritis: including temporal arteritis and polymyalgia rheumatica. *Medicine* 1971; **50**: 1-27.
- 4 Fauchald P, Rygvold O, Øystese B. Temporal arteritis and polymyalgia rheumatica. Clinical and biopsy findings. *Ann Intern Med* 1972; **77**: 845-52.
- 5 Graham E, Holland A, Avery A, Russell R W R. Prognosis in giant cell arteritis. *Br Med J* 1982; **282**: 269-71.

- 6 Jones J G, Hazleman B L. The prognosis and management of polymyalgia rheumatica. *Ann Rheum Dis* 1981; **40**: 1-5.
- 7 Jones J G, Hazleman B L. Polymyalgia rheumatica and giant cell arthritis—a difficult diagnosis. *J R Col Gen Pract* 1981; **31**: 283-8.
- 8 Kinmont P D C, McCallum D I. The aetiology, pathology and course of giant cell arteritis. The possible role of light sensitivity. *Br J Dermatol* 1965; **77**: 193-202.
- 9 Hunder G G, Sheps S G. Intermittent claudication and polymyalgia rheumatica associated with panarteritis. *Arch Intern Med* 1967; **119**: 638-43.
- 10 Mallaya R K, Berry H, Mace B E W, de Beer F C, Pepys M B. Diurnal variation of erythrocyte sedimentation rate related to feeding. *Lancet* 1982; **i**: 389-90.

Statistical power calculations

SIR, When papers report a difference between 2 groups of patients they are expected to give the probability that such a difference (or an even bigger one) could have occurred by chance (the *p* value). Reports of negative findings may provide important information, and these too should be supported by statistical calculations—in this case giving the probability that the *failure* to find a difference between patient groups may have occurred purely by chance (the 'power' of the investigation).

In the *Annals* for June 1983 you published 2 investigations which reported negative findings: the failure of hyperuricaemia to contribute to increased risk of vascular disease¹ and the failure of the type of onset of rheumatoid arthritis to predict subsequent outcome.² The conclusions of both these papers are of interest, but they would have been strengthened by the inclusion of power calculations.³

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References

- 1 Darlington L G, Slack J, Scott J T. Vascular mortality in patients with gout and in their families. *Ann Rheum Dis* 1983; **42**: 270-3.
- 2 Luukkainen R, Isomaki H, Kajander A. Prognostic value of the type of onset of rheumatoid arthritis. *Ann Rheum Dis* 1983; **42**: 274-5.
- 3 Altman D G. Statistics and ethics in medical research, III. How large a sample? *Br Med J* 1980; **281**: 1336-8.

Book reviews

Poliartrita Rheumatoidă. By V. Ciobanu and H. D. Boloşiu. Pp. 485. No price given. Academic Press: Bucharest. 1983.

This book is an excellent up-to-date account of our present knowledge of this disorder, the English summaries (pp. 475-485) giving a short abstract of the contents of the book. Illustrations are black-and-white, clear, and not over-

numerous, references up to date from all countries, mostly in English. One criticism could be that 'Still's syndrome' is called juvenile rheumatoid arthritis, 'the equivalent form of rheumatoid disease' below 16 years of age. The book in general shows that the disorder otherwise seems much the same as we see in our patients here in Great Britain, and gives good wide references from the world's recent literature on the subject.

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