For now, let us exclude the "out" one week, then "back in" next week status of the use of diuretics to treat hypertension and such issues as whether we are helping these people or just treating a number. I can treat hypertension in a selected patient with 25 mg/d of generic hydrochlorothiazide for under $10 per year. Yes, this treatment requires periodic laboratory tests. But so do all medications, and we will be following this population regularly for blood pressure and other cardiovascular risk factors anyway. When should we spend the equivalent of the cost of 20 medication years for ABPM? If ABPM is satisfactory, how often should it be repeated (at such cost)?

I agree in the validity of "white coat" hypertension and the need to be reasonably sure of a condition before treating it.[2] Does this mean, though, that we need to prove everything; and how many times, and how often?

As a physician, I am inundated by (often discrepant) articles about new treatments, new drugs, and new tests. What I really need, now, beyond being told to do things "carefully,"[2] are specific guidelines on how to react to a patient. Which patients have "mild hypertension," and who needs ABPM?

George W. Bock, MDCM
Craig, CO

References

1. Stephens GG. Primary medical care: a riddle and a parable. J Am Board Fam Pract 1992; 5:540-1.
2. McBride PE, Lillis D, Hanson PG. A new standard for the diagnosis of mild hypertension? J Am Board Fam Pract 1992; 5:541-3.

Review of Clinical Guidelines

To the Editor: Congratulations for initiating the first of a series of articles on the important issue of guidelines. I agree with your editorial totally. Two articles that I believe have great value in any reference to guidelines have been done by Stephen H. Woolf, MD, and published by *Archives of Internal Medicine*.

It would also be important for this journal to address the issues pertaining to the implementation, use, teaching, and training in major medical procedures that are underway in many programs. Guidelines and protocols relating to the training and use of these procedures will be an important area, particularly as they pertain to the issues of certification, credentialing, and privileges.

Your comments and thoughts will be helpful to the readership.

Jay R. Varma, MD
Augusta, GA

To the Editor: Congratulations and thanks to you and to Al Berg and Julie Moy for the fine start on the clinical guidelines series. This is exactly what is needed at this stage of the development of guidelines: a precise requirement that anything purporting to be a "clinical guideline" reflect careful research, as well as the realities of clinical practice. I, for one, will be looking forward to the next article in this section.

John A. Lincoln, MD
Turks and Caicos Islands
British West Indies

Streptococcal Toxic Shock

To the Editor: In the September-October 1992 issue of *JABFP*, Dr. David Whittiker describes a fatal case of streptococcal toxic shock. (A fatal case of toxic shock associated with streptococcal cellulitis. JABFP 1992; 5:523-6). He goes on to characterize this entity as a menace to previously healthy young adults, which no one would deny. The case described, however, raises an obvious question.

The patient was a 38-year-old woman who had a history of prostitution and intravenous drug abuse, as well as hysterectomy for cervical neoplasia and therapy for a rectal carcinoma. It should be apparent to all that there was a very high probability this patient harbored the human immunodeficiency virus (HIV), yet this possibility was never addressed in the presentation. The patient's HIV status would clearly have some bearing on the clinical course.

Streptococcal sepsis can indeed lead to fulminant and lethal infection in the *un*compromised host. Nonetheless, I am left wondering whether the patient fits into this category.

Geoffrey Wittig, MD
Dansville, NY

The preceding letter was referred to the author of the article in question, who responds as follows:

To the Editor: Dr. Wittig makes a point. This patient's immune status was undoubtedly compromised with prior cancer of two different origins. However, the patient was HIV negative.

David Whittiker, MD
Wichita Falls, TX